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# The Canadian Nurse

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## JANUARY 1929

### CONTENTS

### PAGE

A GREETING TO THE CANADIAN NURSES	- - - -	<i>Nina D. Gage</i>	3
THE AIMS OF THE INTERNATIONAL COUNCIL OF NURSES	-	<i>Nina D. Gage</i>	4
A PUBLIC HEALTH NURSING PROGRAMME	- - - -	<i>Nan McMann</i>	5
OTTAWA	- - - - -		8
THE LEAGUE'S LATEST ENTERPRISE	- - - -	<i>Jean E. Browne</i>	10
OCCUPATIONAL THERAPY	- - - - -	<i>Genevieve L. Hurd</i>	13
CANADIAN COUNCIL ON CHILD WELFARE	- - - - -		15
CANADIAN TUBERCULOSIS ASSOCIATION—SCHOLARSHIP TOUR	- - -		17
NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES	- - - - -	<i>{Gertrude Williams Jones Emma J. Mitchell}</i>	18
BOOK REVIEWS	- - - - -		21
DEPARTMENT OF NURSING EDUCATION:			
NURSING EDUCATION IN A UNIVERSITY	- -	<i>Gertrude E. Hodgman</i>	22
DEPARTMENT OF PRIVATE DUTY NURSING:			
THE EMOTIONAL DEVELOPMENT OF THE PRE-SCHOOL CHILD	- - - - -	<i>S. Leslie Bell</i>	25
DEPARTMENT OF PUBLIC HEALTH NURSING:			
TRAINING PUBLIC HEALTH NURSES	- - - -	<i>Dr. H. W. Hill</i>	29
NEW TOWN TREATMENT CLINIC	- - - -	<i>} M. E. Misner</i>	30
STOWE HOUSE—AN OPEN AIR SCHOOL	- - - -		
NEWS NOTES	- - - - -		36
OFFICIAL DIRECTORY	- - - - -		45

## A Greeting to the Canadian Nurses

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From NINA D. GAGE, President of the International Council of Nurses

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The nurses of the world are indeed grateful to the Canadian nurses for the delightful way in which they are making plans for entertaining the Congress of the International Council of Nurses next summer. Plans sound more and more attractive, and nurses everywhere are anticipating much pleasure and profit from their visit with you. It was a difficult thing to undertake this entertainment in half the time usually given the hostess country, a curtailment due to activities of the Bolsheviks in China. Realizing this, and the "sporting spirit" in which you have undertaken the project, the nurses are doubly grateful to you.

Due to the war there has not been a Congress of the International Council of Nurses on this side of the Atlantic Ocean since 1901. Consequently most of the younger nurses have missed the thrill of international meetings. Only about 120 Americans and 60 Canadians were able to visit Helsingfors in 1925. Therefore, there is still before you the inspiration and joy of meeting people from all over the world, and realizing that we are all working with the same fundamental problems, and that down underneath the few externals, human behaviour is still the same, whether manifested in Canada or China. Techniques of doing things may vary due to the varying equipment available. General principles to guide action remain the same.

The work of the International Council of Nurses is concerned with nursing not only in member countries, but also in non-affiliated countries where nursing is just being organized. Visitors from these countries will want to see nursing organizations which have been longer organized. We in these institutions can help them in formulating their plans of work, and showing them how similar their foundation principles are to ours. That delightful privilege will be yours, in addition to your others as hostesses for this great gathering. As set forth in the constitution, the International Council of Nurses "aims to provide a means of communication between nurses of various nationalities . . . and to afford facilities for the interchange of international hospitality." You in Canada, having afforded these facilities, will appreciate as never before their great value. And I know that you will feel well repaid for all your efforts by the pleasure you will get in meeting nurses from so many different parts of the earth. Socially and spiritually they will be a joy, and professionally an inspiration as you return to your work after the Congress.

Therefore I am sure that the coming year will be for you the best you have had so far, and I can only wish you many more of equal inspiration, and congratulate you on your opportunities for growth in the New Year.

## *The Aims of the International Council of Nurses*

By NINA D. GAGE

The International Council of Nurses by its constitution says that the nurses of various countries united to advance "the profession of nursing by greater unity of thought, sympathy, and purpose . . . to improve our work in the care of the sick, to promote the health of nations." The aim is to "raise ever higher . . . the public usefulness of their members." "The International Council of Nurses stands for that full development of the human being and citizen in every nurse which shall best enable her to bring her professional knowledge and skill to the many-sided service that modern society demands of her."

This means that the founders of the federation of nurses realized that there are no national boundaries in the service of society, but that the fundamental needs of man are the same the world over—health of mind, body, and spirit—if he is to do his work in the world. The nurse must do her part in helping him attain and retain his health, teaching him what positive health, not just what "not being ill," means in increased efficiency and ability to work. Health of mind, body, and spirit is a very comprehensive term, but nurses all over the world are being asked to show people what it means, and how to get it. It ramifies into all corners of life, and includes many lines of work not thought of years ago. Every year more and more demands are made of our profession. Fifty years ago a nurse was not supposed to take a temperature or pulse. Now that is a routine duty. During the war many nurses were asked to dress wounds which heretofore had been considered entirely a doctor's work. Public health work and preventive medicine are requiring nurses to know much more of hygiene and sanitation than was necessary in former times.

All these new duties must be studied, and the necessary preparation made to fit people to undertake them. What helps one nurse may be of

great assistance to others also, and they should know about it. Only by intercommunication and exchange of ideas, methods, and plans, can improvements in ways of meeting these new duties be made. Epidemics, as that of influenza in 1918, may devastate the world. Nurses can help in preventing the spread of epidemics if they are alive to the best methods, and know with whom to work.

To study these questions; to inquire into the meaning and effects of good nursing; to find out what is wanted of us, and how best to supply that want; to learn how best to co-operate with other people and agencies in constructive health work; to induce better prepared people to enter the profession, so that its work may be better done; to learn what factors influence good nursing, factors political, economic, social, spiritual, physical, mental; these are some of the things on which the International Council of Nurses is trying to throw light by research work. We feel also that the great stimulation of meeting people from widely differing parts of the earth, of having our work judged by our peers as we go from country to country at each quadrennial meeting, cannot but improve the quality of our work. The inspiration of finding that our problems are fundamentally the same the world over, differing only in details, is very great. It very much helps us to better our individual work, and gives us courage to overcome our difficulties, instead of being overcome by them, as is so easy when one feels absolutely isolated.

Working and playing with people of various nationalities, as we do, between and during conferences (at the last conference at Helsingfors 1,050 nurses from 33 different countries talked over mutual problems and difficulties), cannot but break down national barriers, and make for international peace. One cannot hate and fight the people one knows as individuals, whose counsel has helped



one in times of stress. Our membership represents tens of thousands of women and men in many countries. So great a body of people working and thinking towards mutual helpfulness, cannot but react on the citizen body, and make war less possible.

With our full time secretary and headquarters in Geneva, our committees working all over the world, representing all kinds of nursing work, and studying many different aspects of it, and with the results of these studies published by the Council in special monographs, or in our inter-

national magazine, with our headquarters as a clearing house for information and discussion of nursing matters, we are trying to find out what nursing service should mean in a community, and how best we may give it that meaning. Only by a world-wide organization can we do this, as only by world-wide research and mutual help can we evaluate causes and effects, and find how best to solve our problems, and do our part in making the world better and happier.

—(The I. C. N., January, 1926).

## *Nursing Programme in a Community of 5,000 People*

By **NAN McMANN**, Western Supervisor, Victorian Order of Nurses for Canada

The Public Health Nursing programme in the community of 5,000 people is not so very different from that of its bigger sister, except in that it carries perhaps a greater responsibility, as well as a many times greater limitation. The Public Health programme in the small community is so often forced to take under its wing the service that in larger places would be cared for by the special organization. We cannot fail to see that health cannot be promoted in the family where there is not sufficient food to properly sustain life. Wherever we find people grouped together in settlements, we find all classes, from the rich to the very poor and even the slum, the number in each class varying only with the size of the city. And while family social work cannot be regularly delegated to the public health nursing programme, yet many times in the small community we must work through it before we can hope to reach our goal.

We must then seek to give the single service the best qualified nurse available. For, as much will be required of her, she should have at least some knowledge of nutrition and mental hygiene as well as good

public health training and a well-balanced judgment.

In outlining our programme we must, of course, have fully in mind the basic principles essential to a permanent service:

1. Legal foundation of some kind—provincial, municipal or private organization.

2. Proper financial support that will insure good leadership in the form of trained workers.

3. Co-operation of the Board of Health and of the physicians, who, after all, are the guardians of the community health.

With the Board of Health interested and co-operating we will be insured the very basis for good public health work: pure water, safe milk, and proper sanitation.

The small unit calls almost entirely for the generalized service: teaching each member of the community the rules that underlie health. We must keep always in mind that teaching is our main function, whether it be at the bedside, in the class or clinic, or in the home visit. If we are to start at the very beginning, looking toward our goal—the preservation of life and the prevention of disease—we must then concern ourselves first with the expectant mothers. These divide themselves at once into two distinct

(A paper read at the Annual Meeting of the Canadian Public Health Association, 1928, and published by courtesy of the C.P.H.A.)

classes. First, we have the happy-faced, bright-eyed mother, revelling in the joy of a new life, eager for knowledge, with one supreme wish: that her baby may be well born and her own life protected. She has her own physician, but, busy with many things, the days slip by quickly and she fails to consult him until she has passed into the danger zone. The nurse visiting regularly, in addition to urging that she consult her doctor early and frequently, will give her much instruction in the proper care of herself, of her diet, and in general the rules of hygienic living. We may here sometimes forestall the advice of the kindly neighbour, who is always with us.

Against this class we have the pale-faced, over-worked, under-nourished mother, with hardly enough means to cover the daily need and nothing left for medical care for herself. She sees, perhaps, no joy in a new life, only an added burden, and it is to this group, as a public health organization, we owe so much. While we regret that many times these cases are not reported until very late, yet the nurse carrying on the generalized programme soon grows to know the expectant mothers in her area.

The prenatal contact must be most carefully and tactfully made, but once established, the nurse gets very close to the mother and may observe every detail of her daily life. Often the nurse is the only medical contact the woman has until her confinement, and great is her responsibility to watch for the small danger signals and thus forestall disaster. Where prenatal clinics have been established by the medical association or the hospital, the nurse working in close touch with these has found her hand strengthened. Or when the clinic is not indicated, the mothers' class will be of great value as a time-saving device, bringing the mothers together for group instruction and personal checking up. These classes, however, do not have a doctor in attendance and are without value from the point of medical examination. Always we must give first place to the regular systematic home visit where the real personal contact is made.

Here we may speak of the nursing service as a very real part of any public health nursing programme, and especially in the small community. The present-day nursing programme has left far behind it the older conceptions of just care of the sick, and has struck out on the other foot, until now it is considered as playing a very large part in the educational programme. The nurse who has been called by the family and has given them a specific service has indeed an "abundant entrance" into that home. As she works she teaches: teaches, however, from a first-hand knowledge of conditions as they exist, and may it not be that in her comings and goings in that home she has been permitted a peep into the ice-box, the pantry, etc., which might have been denied her as a purely educational visitor?

Who can over-estimate the value of trained obstetrical care during the confinement period and of the postpartum care following? A good prenatal programme may prove useless if proper care cannot be provided for the confinement and postpartum. Truly the baby who has been born, protected by skilled care from the avoidable accidents of birth and carried through his first danger days, will surely be launched into the Child Welfare division unhandicapped. Then the mother who has been taught the proper nursing procedures in the care of her family has surely benefitted greatly from an educational standpoint. For, after all, the care of the sick can only be given through a well-instructed family.

Following the prenatal period with the confinement and postpartum care, we must look to the third and very important phase of the nurse's work: the Child Welfare programme. There are here, however, many things to be studied carefully if an effective programme is to be instituted; for the small community usually places a financial limitation that may, in turn, limit us in regard to the required number of workers. We must then map out a very concise and clear-cut programme if we are to draw the greatest possible interest on our in-

vestment. We may well look carefully into the matter of birth registration and infant mortality as expressed in terms of follow-up work.

Let us then divide the Child Health programme into three distinct phases:

1. Infant.
2. Pre-school.
3. School.

The infant work is again divided into three methods:

1. Clinic.
2. Home Visits.
3. Other Instruction.

The clinic, to the nurse seeking to do a full programme in the small community, is of the greatest value, for the well-equipped clinic for medical examinations and supervision of the infants and young children will enable the nurse to give considerable group instruction, and with an accurate knowledge of weight and development she will then be able to grade her home visits in proportion to the need. The clinic may be held in some central place, and, when under the direction of the medical association, proves most successful. The clinic visit will, of necessity, many times be followed by the home visits for individual instruction and demonstrations, to see that instructions are understood by the mother and interpreted in terms of the home.

Again, when the clinic is impractical, the Baby Conference may be substituted, when the hours would be given entirely to weighing and measuring and giving instructions, with no doctor in attendance.

We must not forget the babies who for any reason are not able to attend clinics or conferences and need the special care of the nurse. These must come under the head of regular home visits. Along with these organized efforts much can be done through an educational attempt toward personal hygiene, with special emphasis on infant hygiene. This might be covered under the head of community classes or a Little Mother's League when time will permit.

Perhaps no part of the child's life is so neglected as the years from two to six, known as the pre-school period.

It is during these years that the baby, sometimes displaced by the new arrival, goes along, either growing normally or developing the various defects of mouth, teeth and eyes, or the more serious defects of bones through faulty nutrition. In many cases these defects go unnoticed until the child enters school, and he must of necessity, then enter school handicapped. We consider that when the Public Health nursing programme can give to the pre-school child his place in the preventive work, so that he may start his school career with teeth, throat and eyes in good condition, vaccinated, and immunized against diphtheria, that his school record will tell a different story. This service may best be done through clinics and by constant urging of the parents to have their pre-school children examined by their physicians, and defects corrected. It is perhaps in the pre-school child programme that we are hemmed in with our greatest limitations.

The school health supervision is a large branch of the Public Health programme that may come under the generalized nursing or may be cared for by the Department of Education. This supervision is, however, given for a five-fold purpose:—

1. To discover physical and mental defects.
2. To protect the community from the spread of communicable disease.
3. For physical education.
4. For teaching the principles of healthy living.
5. To insure proper sanitation of school buildings.

With a definite programme well arranged it would be hard to estimate the value of this phase of public health work in terms of health education. We must remember, however, that the best school work can be done in the prenatal and the pre-school years.

In communicable disease control the public health nurse plays a very definite part. As she goes about through her community, in close touch with the individual family, the suspicious case found and reported may avoid an epidemic. It is here she



must work in close co-operation with the Health Office, visiting the families of reported cases, instructing the family in the conduct of quarantine and isolation, and demonstrating, if necessary, the technique of nursing care.

Then there must often come under the generalized programme that other great branch with which public health is so concerned today—tuberculosis. While the whole public health programme is working steadily toward the defeat of this great enemy, yet it has thrown such a mantle over the community that much intensive education work must be done if any headway in the situation is to be gained. The clinic where expert examination may be given the active, as well as the contact case, is perhaps of greatest value. The follow-up visits should be regular and systematic, and it is to the home teaching that we must look for the final "routing of the enemy".

Whether this phase of the work is under the generalized programme or under the Department of Health, it must be considered one of the utmost importance.

Let us look back and sum up our programme, prepared as it has been, to cover the field of sickness, prevention and care, as well as health education. We may feel that our limitations so outrun our possibilities that we are overwhelmed when we consider the need for this complete health service, yet let us have patience—realizing that the baby must creep before he walks, and walk before he runs. May we then be determined to give to our mothers, who are so quietly laying the foundation of our country, the help and support they so sorely need, and to the children who are our Canada of tomorrow, the privilege of being well born and launched out with a whole rudder and a full sail, as we hand over to them the destiny of our nation.

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## Ottawa

Ottawa, the capital city of Canada, is preparing to welcome the hundreds of nurses who will attend the International Congress at Montreal in July. Ottawa is a hundred and twenty-five miles west of Montreal and has a railway connection with that city of ten trains daily, while the motor drive along either of the provincial highways is a most delightful journey.

Ottawa was chosen as Canada's capital by Queen Victoria more than seventy years ago. It is beautifully situated, the grounds of the Parliament Buildings taking a sheer drop of two hundred feet to the turbulent Ottawa River. Few cities in Canada, or in any other country, are blessed with

so many trees and boulevarded streets. Gardens are Ottawa's glory, and there are forty miles of park-like driveway through the city and its environs.

Of first importance are the Parliament Buildings, a magnificent block of three separate buildings in the Gothic tradition. From their centre rises the Victory Tower, 300 feet high, which contains the beautiful Memorial Chamber. Ten years were spent in the building of this one room. In the centre of the Chamber, on a white stone altar, is the Book of Remembrance, wherein are inscribed the names of those Canadians who gave their lives in the Great War. In the Victory Tower is also the famous carillon of fifty-three bells,



—By courtesy Canadian National Railways.

#### FEDERAL PARLIAMENT BUILDINGS AT NIGHT

the largest musical instrument in the world. To sit in the lovely grounds of the Parliament Buildings, high above the river, and listen to a carillon concert is one of the joys of a visit to Ottawa.

The Victoria Memorial Museum houses the pictures belonging to Canada's National Gallery, as well as one of the most remarkable collections of Indian relics and handiwork in existence.

Lansdowne Park, through which runs the fine government driveway, is the locale of the Central Canada Exhibition, which, in August, draws hundreds of thousands of people from all parts of the continent.

Chaudiere Falls is one of Ottawa's lovely spots, as is also Rockcliffe Park, with its beautiful view of the river.

The thousand-acre Dominion Experimental Farm, with its observatory, laboratories, poultry, bees, horses, orchards, fine greenhouses, and huge flower beds, well repays a visit.

Of particular interest to nurses is Ottawa's Civic Hospital, a group of five buildings situated in their own park just outside the city. These buildings were recently completed at a cost of five million dollars. In the centre of the city is the General Hospital, operated by the Grey Nuns of the Cross, who, last year, added a large wing, perfectly equipped, to their institution.

Other places of interest in Ottawa are Rideau Hall, the residence of the Governor General; the home of the Premier; the Royal Mint; the Dominion Archives; the Sacred Heart Church; the University of Ottawa; Nepean Point Park, and the entrance to the Rideau Canal. The first locks of this canal were built by Colonel By a century ago. In his honour the village was called Bytown, the name latter being changed to Ottawa.

Between Ottawa and Toronto is the famous Rideau Lake fishing country, and north of the city, the Gatineau district, with its wonderful electrica development and its fine lakes and mountains.

## *The League's Latest Enterprise*

By JEAN E. BROWNE,

Director, Junior Section, Canadian Red Cross

Since the League of Red Cross Societies was organized at the famous conference at Cannes in 1919, its few years of existence have been characterized by experiments and adventures on the one hand, and rather remarkable achievements on the other. It seems already to have justified the faith and optimism of its founder, Henry P. Davison, whose mantle of courage and enterprise has fallen on those who succeeded him. Perhaps this spirit has not been more clearly demonstrated than in the recent experiment of the Summer School for "Old Internationals" held during July and August, 1928, at Bedford College.

For those readers who are not familiar with the term "Old Internationals", an explanation of both words may be necessary. The word "Old" is not exactly synonymous with "ancient", nor does the word "Internationals" denote some new and dangerous cult. Rather these are the words used to describe all the nurses who have taken the year's post-graduate work arranged by the League of Red Cross Societies at Bedford College. At the end of the present year 1927-1928, 141 students from 39 countries have profited by this course.

When word went round the world that there was to be a reunion of "Old Internationals" at the Summer School, there was a good deal of speculation as to the number who would come or would be sent by their national Red Cross Societies. Fifty was regarded as an optimistic estimate, but when registration was completed, it was found that there were 79 students from 27 countries. Most of these came from the various European countries, but India, China, Mexico, the United States, and Canada were also represented.

The Summer School opened with the ceremony of the presentation of diplomas to this year's class. Sir Arthur Stanley, Chairman of the British Red

Cross Society, presided, and on the platform were the Lady Mayoress of London, who presented the diplomas; Miss Tuke, Principal of Bedford College; Lady Barrett, Dean (Royal Free Hospital) School of Medicine for Women, University of London; the principal speaker, Colonel Draudt, Vice-Chairman of the League, who gave the opening address; Dame Sarah Swift; Sir Wilmot Herringham; Mr. Kittredge, and Countess Frascara. Before the close of the meeting a vote of thanks was very fittingly proposed by Miss Das of India, representing the East, and seconded by Miss Ruby Hamilton of Canada, representing the West. This was a case where East and West did indeed meet with understanding and sympathy.

After the formal ceremony the guests were entertained at a garden party in the beautiful and spacious grounds of Bedford College. It was a little hard to believe in the reality of this being a garden party in London. It was much more like a pageant of the Heart of the World. Dignified professors in full academic dress from London, from France and other parts of the world were seen gaily chatting with nurses in the costumes of the countries from which they came—China, India, Spain, Greece, Bulgaria, Roumania, Italy, Finland, Belgium—while the more soberly-garbed guests formed a background of the everyday world for this festive scene.

The international aspect was further emphasized by a sale of work contributed by the "Old Internationals". Dolls from Spain, dressed in all the splendour of lace, jewels and embroidery, smiled across at a group of their comrades from Finland. Needlework from Bulgaria vied with the embroideries of Roumania, Greece, Poland, Finland and Italy. Belgium was represented by lace and brass; China by fine linens and satin bags; Austria by delicately painted glassware; English pottery and china were



attractively displayed, and the Canadian Murray Bay homespun blankets introduced the idea of the combination of utility and beauty. The utilitarian aspect of the sale was also demonstrated by the fact that approximately £170 was cleared, and so the debt on the piano at the residence of "Old Internationals" at 15 Manchester Square was wiped out.

By the middle of the first week, the school settled down to work, with lectures all the morning, and to demonstrations, discussions, or excursions to institutions in the afternoons. With no examination at the end of the Summer School, the continued application of the students could only be interpreted as a keen desire for knowledge. The committee which worked out the syllabus for the Summer School is to be congratulated on its wise provision for regular periods of discussion. Those following the lectures served not only as a means of elucidating and emphasizing the points made in the lectures, but also brought out very valuable contributions from the experience of the various students.

The lectures were so arranged as to stimulate thought and discussion. Miss Melhuish, lecturing on the Principles of Education, and Miss Edgell on Ethical Principles and Practical Problems, laid the foundation for the application of these principles to the practical work in training schools for nurses. Miss Gertrude Hodgman, of the staff of the Yale School of Nursing, brought to the classes many illuminating methods of dealing with problems which exist in all training schools for nurses, but her greatest contribution was her elucidation of the scientific attitude towards these problems. Each student in her classes should be better able to face her own special difficulties and to think clearly through her own problems; she should come to depend less on discipline per se, and more on a sympathetic understanding of pupil nurses, and she should come to scrutinize more carefully the traditions of nursing in the light of the present day developments of science. Special

lectures were given by experts on various topics: those on Public Speaking were given by Miss Bell; on Publicity by Miss Smith; on Nursing Legislation by Miss Reimann; on Junior Red Cross by Miss Charlotte Kett; and three remarkable and intensely interesting lectures were given on Mental Hygiene by Dr. Auguste Ley, Professor of Psychiatry, University of Brussels.

In order to appreciate the full value of a course such as this, we must keep in mind the fact that most of the nurses who attended the course are pioneers and leaders in their own countries. Many of them got their first glimpse of public health work and scientific instruction in training schools for nurses during their year's course in Bedford College. Following that, many of the students organized various types of work in their respective countries. There comes a time when the pioneer is apt to be discouraged and depressed, and even grow stale unless she is able to make further contact with those who have met and overcome difficulties similar to those with which she herself is confronted. She needs more information, and, above all, inspiration. It was in order to provide these three essentials that the Summer School at Bedford College was organized. No one who had an opportunity of watching it in operation could harbor the least doubt of its having performed this all-important function. One could almost say that the Summer School was a necessity in order to reap the full benefit of the regular courses which have been in operation for the last seven years.

At meal-time, on Sundays, and on excursions, the Summer School changed into a glad reunion of old and new friends. There were no frontiers in evidence. All were "Old Internationals," no matter of what race, religion or language—an ideal League of Nations in deed if not in words.

Various delightful entertainments were provided. The group was received and entertained at tea by the Lady Mayoress at the Mansion House. On a perfect July day the whole group,

by the aid of three large charabanes, descended on Paddockhurst, the beautiful Sussex estate of Lord and Lady Cowdray. There the students were received by the kind and charming Lady Cowdray and entertained at luncheon and tea. During the interval between luncheon and tea, they wandered over as much as possible of this vast and interesting estate. Lady Beeton was also a charming hostess at her home in Surrey, and considerable additions were made to the general fund of gaiety and good humor by such pleasant occasions as the swimming competitions held at the Royal Automobile Club.

The Summer School ended with a dinner-party to which were invited many distinguished guests. Mlle. Mechelynck, the newly-elected President of the Alumnae of "Old Internationals," acted as Chairman. Toasts were proposed to the League of Red

Cross Societies, Bedford College, the College of Nursing, and the House Committee of 15 Manchester Square. After dinner the guests were entertained with music by several of the students and national groups, and the Summer School closed on a note of harmony, enthusiasm and inspiration.

EDITOR'S NOTE.—No account of the Summer School would be complete without mention of the very great contribution made by Miss Browne herself in her series of eight lectures on the "Principles of Teaching Applied to Health Education". From the background of her own wide experience as teacher, nurse, and Director of the Junior Red Cross, she dealt most illuminatingly with the problems of teaching health to various age groups. To illustrate her lectures, arrangements had been made through the Public Health Section of the College of Nursing for the giving of a health play by a Junior Red Cross Group, a demonstration of home nursing procedures by 'teen-age girls, and mothercraft teaching. Each lecture and demonstration was followed by a discussion led by one of the international students. (

—(The World's Health, October, 1928.)



—By courtesy Canadian National Railways.

THE CHATEAU LAURIER, OTTAWA

## *Occupational Therapy*

By GENEVIEVE L. HURD, Executive Secretary, Victorian Order of Nurses for Canada,  
Montreal District.

The Montreal Branch Victorian Order of Nurses is thirty years old. One of its children, the Occupational Therapy Department, is just three: still in its infancy and still prone to fall into the pitfalls and mistakes of childhood, full of the uncertainties of youth, but with a wise public health mother it has nothing to fear for its future development and life.

The Occupational Therapy Department in Montreal came into being as the result of requests on the part of staff nurses for some sort of occupation for chronic and convalescent patients of the Order; patients who lay in bed day after day, not always in happy surroundings, with no outlet for weary brains, tired hands and sad hearts. Often the four walls of their rooms was the only horizon they had known for months. Soul weariness is reflected in retarding progress towards recovery, and here is where Occupational Therapy, or invalid occupation, as it is sometimes called, is pressed into service.

Occupational Therapy is not a cure in itself. It acts principally as a mental stimulus. It conserves in some degree whatever is left to the patient of healthy functioning, and decreases the feeling of helplessness and hopelessness which is fostered by so many patients, and quite naturally. Where the bread winner is the patient, it is inevitable that he brood over his inability to provide for his family. When the mother is ill, she worries over her inability to care for the family and attend to the details of her home. When the child is ill, it frets and is discontented because it cannot play like other children. Inevitably the result is the same in all cases: a slowing up in the cure

process, because worry and discontent are enemies of repair.

The department operated originally by volunteer workers. For two years now, Financial Federation has granted salary for a craft-worker who is responsible for visiting all cases, preparing work for the patients, arranging for sales of finished goods, and keeping contact with other organizations which may be interested in the particular cases. Three volunteer workers assist her, and their help and advice have been an invaluable aid in building up the work of the department. (Special mention must be made of the wonderful assistance given by Miss Elspet Stephen in lining and finishing the articles before they are ready for market.) It is pioneer work, this Occupational Therapy, the first effort made in Canada to take work to invalids in their homes.

All cases are referred by the nurses who first consult the attending physician as to whether or not occupation would benefit the patient. The Occupational Therapy worker then visits the case. She takes samples of raffia work in which the department specializes, and establishes a contact with the family and patient which is the first step in successful rehabilitation work. It is the rule, rather than the exception, that immediately the patients see the brightly coloured raffia strands and examine the lovely bags and purses which have been made by equally handicapped people, their interest is caught and they are eager to try the work themselves. Unconsciously their outlook on life changes as the work progresses, soon they are competing with other workers, no longer tortured by the feeling of dependency

on someone else: they are independent again.

Frequent consultations with the nurses attending the case, and in special cases with the district superintendent, insures that the patient will not suffer from overwork or strain.

All finished articles which are marketable (in 1927 only five out of some 310 remained unsold) are sold either through the Hwai King Mission Shop in the Mount Royal Hôtel (which charges no commission, but asks that the Victorian Order accept this gesture as proof of their interest in the Order), or are sold to the Canadian Handicraft Guild Shop. As the Guild recognizes only the highest standard in craft work it is obvious that our work is of a first class order. During the annual Guild exhibition in the Art Gallery the department received prizes for three out of five entries.

The cost of the materials plus 10 per cent. to cover transportation costs, etc., is deducted from the selling price of the article, and the net proceeds are given to the patients. No stress is laid on the financial gain from the work, and yet in so many cases the little amount earned has meant warm mittens for Willie, or tobacco for father, or some little gift for mother. In more than one instance the money has helped to buy some necessity—new teeth, crutches, and at present we know of one case where it is being saved to buy—a wooden leg.

During 1927 forty-seven patients were cared for by the department, and 866 visits were made to or on behalf of these patients. Of these patients, there were 9 children, 24 women and 14 men. In ages they range from nine to eighty, and they suffer from diabetes, tuberculosis, heart disease, cancer, arthritis and paralysis. A few of them are incapacitated temporarily only and will eventually recover, but the vast

majority are chronic cases and will continue as wards of the department indefinitely.

There is abundant need for occupation even for those whose cure it does not help. For patients who are not expected to recover and for many chronic sufferers, work and the sight of beauty are as needful as food and sleep. For work and beauty are a large part of what makes life worth living, a powerful aid in the fight against degeneration, boredom, sorrow and despair. To make something beautiful or useful and at the end of a day or a week to see what we have accomplished is to be alive and in some encouraging degree successful, no matter what illness may be doing to us.

The old reliable, our Norwegian sea captain, 80 years old, and a paralytic under the care of the Victorian Order of Nurses for 18 years, is one of the most enthusiastic workers we have. Raffia work did not appeal to him, but wool work did, and he has run the gamut of experience from knitting golf socks and children's reins to embroidering homespun bags. He is never idle, and were he not a grandfather he would be a shining example of the industrious grandmother to the household in which he lives.

Two other patients—a man of 67, paralyzed, and a diabetic woman of "over 70" as she says, were added to the list a few months ago. Both were skeptical of the work—the man because needlework did not appeal to him at all, and the woman because she had done nothing for so long she was quite sure her usefulness was over. It has now become a problem to keep them supplied with work, and almost before the last stitches are secured, interested members of the family are telephoning advance requests for visits. I wish you might see the man half-propped up in bed, smoking his pipe and talking through a cloud of smoke to his next door



neighbour, Tom, who sits with him every afternoon. Much consideration is given by each as to the exact shade of raffia to be used, and the worker is always hailed with delight. Although one pair of hands has fashioned the article, two heads and hearts have gone into the planning of it, and the pride in the finished article is shared equally. No remuneration is accepted for the work: it is a gesture of gratefulness to the Order for the care and attention bestowed by the nurses.

A fifteen year old girl with a serious heart condition presents a difficult problem: to lie in bed all day when one is just fifteen is so hard. Here all the ingenuity and resourcefulness of the worker is called into play, for new designs must be created, colours must be changed, and a

variety of articles planned in order to hold the attention and not allow it to wander too much to toboggan slides and skating rinks and all the other things that one loves when one is fifteen. Occupational Therapy demonstrates here its possibilities for definitely recreational diversion that will gradually but inevitably assist the nurses and doctor in their attempt to build up and consolidate the health processes of the child.

A visit to a display of articles made by these patients demonstrates to some degree what the department accomplished tangibly in three years. It does not tell of the brightness and hope and interest that have been brought back to many of our patients: the intangible, elusive values which are a part of existence and cannot be expressed in concrete form.

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## *Canadian Council on Child Welfare*

At the ninth annual meeting of the Canadian Council on Child Welfare held in Ottawa on October 22nd, 1928, the Canadian Nurses Association was represented by Miss G. Garvin and Miss G. Bennett, of Ottawa. During the same week round table conferences were held on Child Labour, Juvenile Delinquency, and Juvenile Immigration.

The executive secretary's comprehensive report covered the development and expansion of the Council during the past three years. In referring to the Council's general educational services it was explained that the Council's function is interpreted as primarily that of an educational agency, co-ordinating public and private endeavour in the Canadian child

welfare fields and seeking closer co-ordination of the principles and practices dominating such effort within the different provinces of Canada.

Among the many activities receiving the attention of the Council is that of health education for teachers in training. The Council stresses definite training by instruction through physicians and public health nurses for public and personal health of all teachers in training in the provincial normal schools. Such services are now provided in all the provinces except Ontario and Quebec. The subject is definitely under consideration for adoption in the former province.

In adopting the report of the Child Hygiene Section the Council approved

the suggestion that in the next three years this section concentrate largely on prenatal and maternal care, and infant and pre-school welfare, with special emphasis on breast feeding and nutrition. The plan includes:

1. The appointment of one full-time worker to the staff of the Canadian Council on Child Welfare, to give entire time to these publications and their distribution. As at present, the publications would be prepared by authorities on the various subjects, who are actually at work in this field. The Council would continue to be a publishing, distributing and educational agency. This worker would be an experienced Canadian public health nurse.

2. The regular publication of maternal and child welfare articles in various Canadian publications, as already arranged. These would be varied and regular, as the appointment proposed would make this possible.

3. The more intensive distribution, in co-operation with the provincial departments of health, as already arranged, of the prenatal letters in English and French.

4. The widespread distribution, through the present channels, of diet folders, health folders, etc.

5. The creation of a special maternal and child health exhibit, parts of which are already available for loan to health and women's organizations, etc.

6. Special distribution and educational work, by the person in charge of this department, through the medium of summer and fall fairs, summer picnics, Sunday school gatherings, women's conferences, etc.

7. All work carried on, as at present, to be in close co-operation with provincial and municipal health authorities. The Council, being a purely educational agency, with no operative interests in any community, is peculiarly fitted for co-operative health education work with the different public and private agencies, operating in this field.

The revised and amended constitution of the Council makes provision for the enrollment of Sustaining Patrons—"Any organization, institution, or agency interested in the objects of the Council, with the approval of the Governing Board and on payment of not less than ten dollars per year, may be enrolled, and shall be entitled to receive:

1. All publications of the Council.
2. Privileges of the offices of the Council for information service.
3. Assistance of the officers of the Council in co-ordinating child welfare programmes, or in outlining child welfare investigations.

4. Facilities of the Council offices for educational publicity.

5. Facilities of the Conference for educational publicity.

6. Consultant services of the officers of the Council as desired.

The by-law governing membership was revised to read:

1. Membership shall consist of two classes:

- (a) Organization Members.

- (b) Individual Members.

2. Organization membership shall be open to any organization, institution, agency, group, etc., having the progress of Canadian child welfare in any phase, included, wholly or in part, in their programme or general activities.

3. Individual membership shall be open to any individual interested in or engaged in child welfare work in Canada, upon payment of the usual membership fee, whether that individual is in the employ of any government in Canada, or not.

4. Notwithstanding anything contained in this section, the Governing Board reserves the right to refuse any application for any class of membership in the Canadian Council on Child Welfare, and further reserves the right to request the resignation of any member from membership in the Canadian Council on Child Welfare.

5. Organisation membership shall be of two classes:

- (a) National Membership—National membership shall be restricted to organizations provincially incorporated, or submitting with their application for membership, evidence of active work, and existing organisation within, at least, four provinces of Canada.

- (b) Provincial Membership—Provincial membership shall be restricted to organisations provincially incorporated, or submitting with their application for membership, evidence of active work, and existing organisation, on a provincial scope, within the province of application.

- (c) Municipal Membership—Municipal membership shall be restricted to organisations local in their organisation, scope and activities.

The work of the Council will be carried on under the following sections:

Child Hygiene.

The Child in Employment.

Recreation.

Education.

The Child in Need of Special Care.

Delinquency.

The Spiritual and Ethical Development of the Child.

The French-speaking Section.

## *Scholarship Tour, Canadian Tuberculosis Association*

Recently thirty-five medical men, members of the Canadian Tuberculosis Association, spent eleven weeks touring Great Britain and Europe, during which time they attended the Conference of the International Union against Tuberculosis, held in Rome from September 25th to 28th. This tour was made possible mainly through the generosity of the Sun Life Assurance Company of Canada.

While the itinerary was planned to include as many places of professional interest as possible, no opportunity was neglected to visit also places of more general interest for their natural beauty or historic association.

Upon the return of the party, Dr. R. E. Woodehouse, executive secretary of the Canadian Tuberculosis Association, issued the following official statement:

"The itinerary included Great Britain, France, Switzerland and Italy. The impressions of representative members indicate that the tour has been not only extremely interesting but most instructive. The attention of the medical members was directed to matters pertaining to tuberculosis and to various public health aspects both in administration and practice.

"Among the problems investigated were the following: Municipal housing schemes, sanatorium construction and equipment, diagnostic and therapeutic measures, post sanatorium care of the tuberculous, infant and child welfare, special measures and activities to protect children from infection, governmental and voluntary contributions to maintenance and construction programmes, public health activities and administration as exemplified in such cities as Birmingham, London,

Paris, Edinburgh and Glasgow and the national Fascist Federation and Insurance plan of Italy.

"Such a comprehensive plan of investigation naturally resulted in a vast amount of valuable information being obtained which, on further assimilation, may result in some practical measures applicable to Canada being evolved.

"Having in mind the density of population in European countries as compared to that of Canada and the difference in climatic conditions, it is easy to appreciate that it is difficult to transplant ideas, methods of administration, or types of construction, without adequate adaption.

"Among the most striking activities noted were:

"(1) The protection of the uninfected child from disease.

"(2) National insurance schemes, carrying benefits of treatment.

"(3) Municipal housing schemes, displacing slum areas with hygienic homes.

"(4) While it seems to be a common practice in Europe for governments and municipalities to make very liberal contributions towards defraying the cost, both of construction of sanatorium buildings and of the main entrance of patients therein, there is still a large field for voluntary effort, and this obligation is being very generously met by the general public.

"The wonderful hospitality and courtesy extended by three national governments, national tuberculosis associations in England, Wales, Scotland and in France, six universities, the office of the League of Nations at Geneva, as well as that of numerous municipalities and hundreds of individuals, made the tour a remarkable privilege throughout."

## *New Brunswick Association of Registered Nurses*

By GERTRUDE WILLIAMS JONES and EMMA MITCHELL

When a nurse graduated in New Brunswick, prior to 1903 (and for some years after), she took up private duty as a matter of course, for very few institutional positions were filled by nurses at that time, and almost no other line of nursing service was open in the province.

Three friends, classmates, graduates of the Saint John General Hospital Training School, meeting as often as was possible, constantly discussed their individual problems, and, feeling the need for such interchange of ideas and experiences with other nurses, agreed that a nurses' society was desirable. During the preliminary work of organization, these nurses, Miss Melissa A. Brown (Mrs. J. Arthur Freeze, Sussex, N.B.), Miss Ada A. Burns, now superintendent of V.O. Nurses, Saint John, and Miss M. Gertrude Williams (Mrs. Walter S. Jones, Albert, N.B.), received valuable assistance and advice from the late J. H. Scammell, M.D., of Saint John.

All graduates of the Saint John General Public Hospital were invited to meet in the rooms of the Saint John Medical Society, on April 1st, 1903. Sixteen nurses responded and warmly endorsed the idea of forming an association, as they fully realized that an organized society would be of much benefit to the increasing number of graduate nurses in the city. At this meeting was organized the Graduate Nurses Society of the Saint John General Hospital. Dr. J. H. Scammell and Dr. T. Dyson Walker, members of the staff of the General Public Hospital, were present and gave valuable suggestions as to the future possibilities of such a society, giving the nurses every encouragement in their new undertaking.

The sixteen charter members of the society are: Mrs. M. Armstrong, Miss A. Delaney, Mrs. Brittain, Miss Ida Smith, Miss A. M. Pitt, Miss M. M. Holder, Miss M. Wetmore, Mrs. P. J. Donohue, Miss M. E. Robertson, Miss Julia Murphy, Miss Marion Smith, Miss M. Gertrude Williams,

Miss Isabel Stewart, Miss Melissa A. Brown, Miss M. A. Miller. The first officers elected were: President, Miss Isabel Stewart; First Vice-President, Miss M. Gertrude Williams; Second Vice-President, Mrs. P. H. Donohue; Secretary, Miss Melissa A. Brown; Treasurer, Miss Mary Robertson.

The president appointed a committee on Constitution and By-Laws: Miss M. G. Williams, Miss G. Pitt, Miss M. Brown, and a second committee on Membership Fees: Miss M. Miller, Miss M. Smith, Miss M. Holder, and Miss K. Holt.

The main objects of the society were:

1. The union of graduates for mutual help and protection.

2. To promote the interests and good standing of the nursing profession, and, first of all, of their own school.

3. To promote social intercourse and friendliness among graduates, also to arrange for a uniform fee and to establish a registry, enrolling only graduate nurses.

The early general meetings of the society were held in Doctor Scammell's office, as the renting of a heated room was too expensive for the infant society. Later, the Commissioners of the General Public Hospital offered the use of the Board Room, which was gratefully accepted, and was the meeting place of the Society for some years. The meetings are now held in the lecture room of the nurses' home, and the Association has enrolled one hundred and ninety-two members.

The first work accomplished was the establishment of a registry in Saint John, all nurses holding diplomas being enrolled on payment of a small fee. All doctors in New Brunswick were notified that the registry would answer day and night calls and endeavour to supply nurses as required.

Early in its history, the Society spent a great deal of time and energy in trying to start a library where



nursing and medical literature might be kept for reference and where the Society papers could be permanently stored.

The Saint John Women's Council warmly congratulated the nurses on their successful efforts to organize another women's society in Saint John and invited affiliation with the Council. Later, the nurses accepted the invitation, fully realizing the advantages offered by such a connection.

In March, 1904, the Society purchased an oxygen outfit and, while oxygen was a popular remedy, the doctors of the whole province depended upon this source of supply. The late Dr. T. D. Walker gave a demonstration to teach the nurses how to use and care for the apparatus. The Society deeply appreciates the faithful and efficient manner in which the registrar at that time, Miss Hattie Hunter, carried on the nurses registry and managed the oxygen business. The oxygen proved quite an asset; many urgent calls were received and filled promptly, all New Brunswick hospitals getting their oxygen from the Society.

During the first year, twenty-nine nurses were enrolled as members of the Society, a registry for nurses was established, and an oxygen outfit purchased. It is interesting to note that during the year ending April 1st, 1906, the following calls were received at the registry, three hundred and sixteen calls, one hundred and forty-two from city doctors, seven from Nova Scotia, twenty-five from places in New Brunswick, and fourteen calls came from six hospitals. Since the registry office had only been opened in May, 1903, this record was most encouraging.

After six years of activity, the Graduate Nurses Society of the Saint John General Public Hospital decided that the time was ripe for enlarging its boundaries, as the registry carried names of many nurses who were graduates of outside schools. With this object in view, on March 1st, 1909, the parent association sank its identity in the organization of the

Saint John Graduate Nurses Association, which admitted to membership any properly qualified graduate nurse, resident in Saint John. It is interesting to look back and see how localized the efforts were in the days when communication and transportation were slower. One feels sure that it was not through selfish motives that the pioneer Society confined its membership and interests to graduates of one hospital. It was due, rather, to modesty and lack of vision in not realizing that from such a small beginning a great work would grow.

In 1910 the Graduate Nurses Association started a Sick Nurses' Benefit Fund. The Opera House management agreed to let the nurses put on a specially advertised movie show, when nurses in uniform sold tickets and did the ushering. The people responded magnificently with packed houses at two performances, many being unable to gain admission. The Association, through the establishment of this fund, has been able to accomplish much good in assisting sick nurses.

In 1914, the Saint John Graduate Nurses Association became affiliated with the Canadian National Association of Trained Nurses. In 1915, the sum of \$60.00 per year for four years was pledged to further the interests of *The Canadian Nurse*. This is a very useful and interesting magazine and improves steadily.

During the first year of the Great War the membership of the Association increased rapidly, as the Department of Militia and Defence required applicants to the C.A.M.C.N.S. to be members of nursing organizations in their own province. Young women flocked home to Saint John in order to volunteer for overseas duty. Therefore, in 1915, the membership and scope of the effort had again outgrown the name of the Saint John Graduate Nurses Association and become the New Brunswick Association of Graduate Nurses at the adolescent age of twelve years, and at once prepared to shoulder adult responsibilities. The first step was the securing of the incorporation of the Association and the provincial registration of nurses, thus raising the standard

of nursing in New Brunswick and assuring the prospective pupil nurse of a definite and recognized curriculum.

The Nurses' Bill as prepared by the Nurses' Committee asked for a minimum average of twenty-five daily occupied beds, but the Association was obliged to lower this to fifteen beds in order to secure the passing of the Bill. This low average seemed a tragedy to the applicants, but the several small hospitals in the province had to be considered. Later, some hospitals met the required standard through affiliation with larger hospitals, while others aimed to accomplish the raised standard in their own institutions. The Bill made provision for C.A.M.C. nurses absent on overseas duty and for qualified nurses in New Brunswick, giving the latter two years in which to join the Association and become registered. The nurses in training at the time of the passing of the Act (April 29, 1916) were also given consideration. The overseas nurses gave no trouble, but many nurses resident in New Brunswick did not seem to be aware that New Brunswick provincial registration of nurses was of any value until the two years had expired and the incorporated association began to require that applicants for membership meet the required standard. Then many nurses asked for concessions on various grounds. The object in giving the two years waiver was that all New Brunswick nurses might be eligible for membership in the Association and for registration, and might thus all start equal as to qualification. It is regrettable that several times since the expiration of the waiver it has been found expedient to lower the standard of qualification for membership in favour of those delinquents who failed to take advantage of the waiver.

In order to control membership in the Association, it was necessary to legally secure the name of the New Brunswick Association of Registered Nurses, which name seems capable of covering any state of growth that may be attained. By affiliation with the Canadian Nurses Association the New Brunswick Association is connected with national and international nursing organizations.

Registration certificates were first issued in 1916, and the first examination was held in Saint John on March 26th and 27th, 1919. These examinations are now held twice a year in different parts of the province. The Association took a census of the province re emergency for the Red Cross under the convensorship of Miss Ada Burns. A survey of the Province was recently made in the interests of subsidiary nursing service for the Canadian Nurses Association, under the convensorship of Miss Mabel McMullin.

Miss Elizabeth Robinson Scovil, a New Brunswick nurse of outstanding character and ability, has been made a life member.

The superintendents of the New Brunswick hospitals have united in an effort to have uniform hospital records adopted, and a standard curriculum (minimum) has been approved and adopted. The Association also approved of general hospitals affiliating with the tuberculosis sanatorium and including a short period of training in this work before graduation.

The several standing committees appointed are: Public Health, Private Duty, Nursing Education, Constitution and By-Laws. It is the hope of the New Brunswick Association of Registered Nurses that a minimum standard for hospitals will soon be adopted in Canada and that all Canadian training schools may be registered at Ottawa.

In 1928 membership increased. At the time of writing there are 617 nurses registered in New Brunswick. There are enrolled on the local registry at Saint John sixty-six nurses. There are four chapters of Registered Nurses active in the province, at Saint John, St. Stephen, Moncton, and Fredericton. Saint John Chapter has a membership of 192.

At the 1928 annual meeting it was decided to seek legislation to raise the average of daily occupied beds from fifteen to thirty-five, and to require prospective pupil nurses to have at least one year's high school education.

The Association is deeply indebted to Mr. A. P. Barnhill and to his successor in office, Mr. C. F. Sanford,

for legal service and advice. These busy men have freely given of their time, service, and ability to help further the work of the Association in its efforts to secure and maintain good standards of nursing.

The following is a list of presidents of the Association, 1903-1928: Miss Isabel Stewart, Mrs. W. O. Dunham, Miss M. G. Williams, Miss E. J. Mitchell, Miss E. P. Hegan, Miss A. Branscombe, Miss M. G. Williams (second term), Miss Charlotte Brown, Miss Margaret Murdoch, Miss A. J. MacMaster.

For many years the work of the Association was carried on without

remuneration to any officer (except to the registrar of the local nurses registry at Saint John), though the work often demanded more time than a busy nurse could well afford to give to it. Perhaps the most outstanding instance was the difficult office of treasurer, held so efficiently by Miss Emma J. Mitchell for a number of years, until the increasing work became really a burden. The last four years the Association has paid a nominal salary to the secretary-treasurer, who is also registrar, and in that office arranges for and conducts the examinations for registration of nurses twice a year.

#### BOOK REVIEWS

**Parents and the Pre-School Child**, by William E. Blatz, Associate Professor of Psychology, University of Toronto, and Helen Bott, Instructor in charge of the Parents' Education Division, St. George's School for Child Study, Toronto. J. M. Dent & Sons, \$1.50.

This book will receive a warm welcome from those who already know of the work that the authors are doing at the University of Toronto in connection with child study and with the teaching of psychology: rather impatiently their students have been waiting for a text book from them, and now, happily, the text has appeared. The book is written directly for those who have responsibility for the daily training of children and the fortunate nature of the presentation is characterized by the English reviewer in the "Times," who says that it is "as far removed from the dryness of clinical research on the one hand as from nursery advice of the commonplace kind on the other."

The book will have great usefulness in that the teaching is presented in an eminently practical form so that all who will may understand and may receive guidance in meeting their immediate difficulties, and woven through this practical presentation is a simple exposition of the underlying science of psychology. The simplicity of the presentation may be deceptive to the superficial reader and may obscure the depth of research that is presented. The book offers a truly healthy approach to the study of mental hygiene and thereby meets a widely-felt want. Thus it is a text that should be of great

interest to all nurses: it is very much needed by public health nurses, but not more by them than by all other practising members of the profession.

—E. Kathleen Russell.

**The Fundamentals of Chemistry: Its Application to Nursing**: Jean Bogert, Philadelphia; 2nd ed. W. B. Saunders Co., 1928. Canadian agents, McAlinsh & Co., Ltd., Toronto; price \$2.75.

Throughout the first section of this book, the section on Chemical Theories and Inorganic Chemistry, there is a tendency to present chemical theory in such a way that its usefulness will hardly be grasped. When, for example, a student of elementary chemistry is told somewhat dogmatically that matter consists of positive and negative electrical units he is apt to believe it and he may imagine that he has acquired useful knowledge, which most certainly he has not acquired.

Nevertheless, the book has many good features. There is throughout frequent reference to and illustrations of the applications of chemical knowledge: applications which should be of particular interest to nurses. Much useful data have been set forth in tabular form. Among these there is a very concise summary of important organic compounds under the heading, name, formula, properties, etc. Other tables have to do with digestive enzymes, constituents of the blood in diseased and normal individuals, general properties of urine, poisons and their antidotes and other subjects.

P. J. Moloney, M.D.

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,  
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

### *Nursing Education in a University*

By GERTRUDE E. HODGMAN

Assistant Professor of Nursing, Yale University

*And I say that life is indeed darkness save when there is urge,  
And all urge is blind save when there is knowledge,  
And all knowledge is vain save when there is work,  
And all work is empty save when there is love.*

KALIL GIBRAN, in "The Prophet."

Why should the education of nurses be carried on in a university? I presume that this is a question which has been asked in many parts of the world, and answered in many different ways. Doubtless many have said that nursing education has nothing to do with university education because technical skill based on training is needed in nursing, rather than knowledge based on education. Others have answered that skill and understanding must go together in nursing, and that skill in itself may be knowledge. Some have answered that devotion and service are the essential qualities in nursing and these things are not learned in a university. Others have said that such devotion and service can only find expression satisfactorily in these days when knowledge in hygiene and medicine, sociology, psychology, and other sciences is increasing so rapidly, through understanding of the material and principles of these sciences. Some have said that nursing is not a profession. Others claim that it meets the requirements of a profession, has a calling which has acquired "both social usefulness and intellectual distinction."

It is, perhaps, with the hope that nursing may become of even greater social usefulness, and may ultimately gain that intellectual distinction which the greatly enlarging scope of its activities and opportunities would seem to warrant, that the leaders of the profession are turning to the universities and asking to be admitted.

In the United States at the present time there are an increasing number of nursing schools which have some connection with a university. In most instances this takes the form of a five-year programme divided between university courses and instruction and experience in a hospital. It usually leads to a Bachelor of Science degree and diploma in nursing. The students in these courses are a recognized group in the university and take the required and elective courses of the nursing curriculum in classes with the other students of the university. This provides an excellent background for nursing. In almost every instance, however, the education which these students receive in nursing *per se*, theory and practice, in the hospital, can be said to be only very gradually measuring up in any degree to what may be considered a satisfactory university standard. There are two fundamental reasons for this. First, that except in two or three places there are no adequate funds to provide for the necessary number of qualified instructors, and for other facilities for teaching, during the period of practical experience. Also the students themselves are required to do more of the hospital work than is commensurate with either their educational needs or their continued energy of mind and imaginative consideration of the work in which they are engaged. These are qualities which we would hope to have developed during periods set aside for education. They are qualities which are needed in nursing,



for nursing has the opportunity to become one of the greatest of forces for constructive social betterment of our time. It must not be content with palliative measures and short-sighted policies. It must learn to act co-operatively, social-mindedly, constructively, imaginatively. These qualities have never been developed or maintained by teachers or pupils under conditions of worry, restraint, continuous routine, limited opportunities for contacts with other fields of endeavour, and lack of leisure. Yet this describes the very conditions of the usual hospital experience of the students and of the teachers in the nursing schools where the service of students is depended upon for the full care of all patients in the hospital—largely as a measure of economy to the hospital.

### Study and Experiment

In the second place, opportunity for study and experimentation in methods of teaching nursing has not yet been possible to any degree, due to this very lack of adequate funds designed for this special purpose. For the past five years the School of Nursing at Yale University has been studying nursing education under circumstances which would seem to make such a study possible and valuable. The School is an independent one in Yale University. It has funds for its purposes. The New Haven Hospital, with which the Yale Medical School affiliates, also co-operates with the Nursing School. This co-operation permits the school to direct the nursing service of the hospital through joint appointment of the nursing staff. In other words, professors and instructors and assistants in the nursing school also have positions as superintendents of nurses, assistants, supervisors, and head nurses in the hospital. At the same time the school is free to arrange for such experiences in nursing activities other than those offered in the hospital, as it considers desirable for the education of the student. In this way students receive experience in a nursery school, a mental hospital, the out-patient clinics of the hospital, and with the community visiting

nurse association. In each of these places, the school is assured of the proper instruction of its students through the joint appointment of a qualified person on the staff of the activity and on the school faculty (there is one exception where such an appointment by the school has not been made. The school is assured by other means of satisfactory instruction).

The admission requirements to the school have been set at a minimum of at least two years of college work. The majority of students, to date, have the Bachelor's degree before entering. This high entrance requirement, together with the facilities above mentioned, have made it possible for this school to concentrate its greatest attention upon the actual teaching of the vocation of nursing. It is the aim of the school, through the development of better teaching methods, to hold the length of the course to as short a period as is consistently possible.

### Some Principles

Since we feel at Yale that only a beginning has been made in developing more satisfactory methods of teaching than have hitherto been possible, and there is much more to be done and learnt before the best ideals of a real university education in nursing are accomplished, it will be desirable here only to list briefly some of the principles upon which the teaching methods are being developed. These are:

First, a definitely planned curriculum using the fundamental sciences—anatomy and physiology, bacteriology, psychology and chemistry as a scientific basis—and the actual experience in nursing, graded according to difficulty, as the "project" through which the teaching is carried on.

Second, a close correlation between theory and practice; the medical and nursing theory either immediately preceding or being taught during the period of experience in any service. This correlation is also developed through the following methods of ward teaching: (a) Immediate and systematic supervision of students' work by instructors and assistants.

(b) Written "case experience records" by the student, which teach a method of study of cases, and an evaluation of experience. These are supervised through individual and group discussions of the nursing care of patients. (c) "Case studies" which bring to the student's attention all of the factors related to the health problem—nursing, medical, social, individual.

Third, the curriculum aims to prepare the student for the first grade of position in any phase of nursing work—private duty, institutional, public health.

Fourth, hours of work which more nearly approach those of other student groups, i.e. forty-four hours a week, including class and practical work.

Fifth, a faculty qualified for university appointments.

Sixth, funds to pay for the various necessary activities of the school, such as (a) fees and salaries for lecturers and instructors, (b) health supervision (this is used as an important method of instruction), (c) comfortable and attractive living conditions.

Seventh, a satisfactory service for patients is provided through the employment of a staff of graduate nurses,

and supplementary assistants, such as maids, ward-helpers, orderlies, etc. A satisfactory service for patients is essential to any good teaching programme.

Lastly, I think we should speak of the principle of university relationship. For where else but to the university may we look for the help we need in developing nursing education? Through what other agency may we be able to connect this social art with the science and art of other enterprises of modern life? Just as medicine and engineering and forestry and business and drama have found their way into the university—so is nursing finding its way.

Nursing has at least one element which seems to be common to all people and all times—its appeal to women of fine character. The "urge" of nursing appeals to many of the finest women of our day. For these especially the university offers knowledge and with it "some hope of containing an imagination disciplined by detailed facts and necessary habits."\*

\*Alfred North Whitehead: "Universities and their Function," "Atlantic Monthly," May, 1928.

—"The World's Health," October, 1928.

## *International Council of Nurses*

The Committee on Arrangements, through its various sub-committees, is making progress with preparations for the International Congress. The reports of the meetings held frequently impress one with the thorough way in which our representatives are acting for the members of the C.N.A.

The Montreal High School, University Street, has been secured for general headquarters, as well as headquarters for the Nursing Education Section. Public Health Headquarters will be in the Mount Royal Hotel and Private Duty Headquarters in the Windsor Hotel.

The sub-committee on housing of the Committee on Arrangements have planned that hotel accommodation will be allotted as follows: Public Health nurses, Mount Royal; Private Duty, Windsor; Education, both; Board of Directors and Grand Council, Ritz.

Canadian nurses planning to attend the Congress are requested to aid the Committee on Arrangements by sending in

their applications for accommodation at an early date. Applications to be sent to: Committee on Arrangements, Royal Victoria Hospital, Montreal. The rates for rooms in the large hotels are as follows:

Single room .....	\$3.00—\$ 4.00
Single room, with bath.....	5.00— 7.00
Double room .....	5.00— 7.00
Double room, with bath.....	8.00— 10.00
Large room, 3 persons.....	7.50— 10.00
Large room, 4 persons.....	8.00— 12.00

Rates for bed and breakfast in convents are from \$1.25 to \$1.50.

Rates in boarding houses vary according to location and accommodation offered.

On arrival in Montreal visitors are requested to report to Headquarters, the Montreal High School, University Street, for room assignment.

The sub-committee on exhibits announce that application for exhibits' space and the amount required should be made before March 1st, 1929, to Miss C. M. Ferguson, Royal Victoria Hospital, Montreal.

## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
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### *\*The Emotional Development of the Pre-School Child*

By SARA LESLIE BELL, Montreal

In considering the emotional development of the pre-school child as distinguished from motor or language development, or the mental and intellectual development, it is to be understood that the distinction is merely one of convenience. Gesell tells us "most distinctions in psychology are for convenience. They are necessarily artificial, aiming to aid in interpretation or application."

Whereas adaptive development may be taken to mean, roughly, the child's adapting of such impersonal things as blocks, pieces of wood, etc., emotional or personal-social development refers to responses or habituations of a personal being in a social environment. It is conditioned by social impressions and pre-supposes capacity to profit by experiences.

Emotions are all related to instincts; they are the feeling-aspect of instinctive reactions. Since instinct dominates so much more of the behaviour of children than of adults, the emotions also are relatively stronger and less well controlled in childhood; so if we are ever to learn the true meaning and significance of the emotions it will be by the direct study of their objective manifestations in childhood and adolescence. The laws of physical and mental growth condition the capacity to experience many of the emotions because they condition the birth of instincts. Apart from which the emotion cannot

be experienced. (Waddle, pp. 108, 190: Introduction to Child Psychology.)

Periods when many instincts are coming to their full strength are therefore periods of emotional stress. Emotions are best studied at these periods because then they are more spontaneous and unrestrained. The outward or organic expression of emotions seems to be marked by a certain periodicity, a waxing and waning of strength with rather marked high points at four and five years, and again just following pubescence, with a decline thereafter. Hall contends that feelings and emotions make up nine-tenths of life and are vastly more important and fundamental, and are not only far greater in volume than thought, but that their power for determining conduct outweighs reason many fold. As yet we know very little about the conscious aspect of the child's emotional life; and its proper evaluation and use in life and education is largely a problem of the future.

To any who ask why we should make a study of children under five years of age Dr. Watson answers as follows: Because

1. Children of five and over are enormously sophisticated.

2. The pattern of the future individual is laid down by the end of the second year. Many things which go into the making of this pattern are under the control of parents, but as yet nothing has been done to make them aware of them.

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(\*Published in "Babyhood," May, 1928 and now appearing with permission of Babyhood, Inc.)

3. The psychology of human instincts and emotions cannot be obtained by mere observation of adults.

4. It is the only way of obtaining data for the enumeration of men's original tendencies, following through the development of activity of *many* infants from birth to advanced childhood.

5. If a proper analysis of the activity streams can be made at a very early age the whole care of the child may be altered with beneficial results. (Watson: *Studies in Infant Psychology*.)

The phenomenon of personality development is so complicated that it is difficult to find solid ground for generalization: the child's mental structure is ramified and complicated, but we may see the beginnings of behaviour with an emotional quality in the angry cry of a new-born babe.

Inborn propensities assert themselves at ascending stages; there is a basic continuity of development. No sharp beginnings or abrupt endings: emotional possibilities are born with the baby as well as his mental and physical possibilities. Emotional control is therefore an important index of personality maturity.

Many specific emotions are characteristic of particular instincts; the relation between them is one of correspondence—thus the instinctive reaction to flight calls forth the emotion fear. The instinctive reaction pugnacity—anger. (Waddle: p. 108, "An Introduction to Child Psychology.")

The emotional abandon of certain periods and for certain emotions can be closely correlated with the nascency of certain instincts, such as those of self-preservation, pugnacity, sex and the like. Children experience fear, anger, and perhaps disgust in the presence of persons or objects which naturally excite such emotions, but they do not cherish hate as an abiding sentiment when the exciting object is absent. That comes only when "an

organized system of emotional tendencies centred about some object" has been formed. It is the sentiments, as thus defined, which bring order and continuity into the chaos of the primitive emotional life.

Darwin tells us that his boy showed what he considered evidence of incipient emotion, anger, as early as the eighth day.

A scale of active expressions is accomplished in the second and third months. These expressions may be "classified" as:

A. Organic feelings. Those having to do with the vegetative life of the infant: hunger, discomfort from being wet, pronounced movements of like and dislike.

B. Feelings with regard to things: i.e., bright light, colours, etc.

C. Feelings with regard to persons.

In the later months of the first year can be observed manifestations of the beginnings of sympathy and love.

Idelberger, observing his son uninterruptedly for one hour during the end of the first year noted down everything the babe did, from which observation the following information was obtained:

1. Almost absolute predominance of activities of will and emotions over the still very small intellectual function.

2. Surprising variety in kind and direction of emotions—that one hour shows joy and sorrow, curiosity and surprise, anger and displeasure, desire and aversion.

3. Impulsive and disconnected character of the psychic life—the incapability of any continuous concentration or of persistence in the pursuit of any one interest.

Even in the period before speech there are to be seen evidences of sympathetic feelings; at six or eight months the babe greets its mother with outstretched arms. There is no real understanding as yet, but by degrees this beginning develops into true sympathy.



**ANGER.**—Certainly shown by the fourth month. At first caused by delay in supplying food, but two or three months later it is called forth by any thwarting of desire. Especially is this so if the movements of the child are hampered: i.e., holding its nose to make it swallow; pinning down the hands, etc. Scupin records (Stern: p. 126) that anger, self-will, fear, defiance, disappointment are all evident at 5½ months. All this, of course, is instinctive in character: nothing conventional or acquired.

**FEAR.**—Considered by all authorities to be instinctive because it is of unlearned character and present from birth. It seems, at first, always to be caused:

1. By a feeling of loss of support, such as being "dropped" over a pillow.

2. By loud noises. *Third month:* Due almost always to loud or unexpected noises, surprise, unexpected sights and sounds. *Fourth month:* Fear of things seen: fear of strange places; fear of the dark (4th month and later). This last closely connected with imagination. *Sixth month:* Fear of things seen is called out by a strange face. Bashfulness is an offshoot of fear, a survival of what in our ancestors was active terror. This is succeeded in the second year by self-consciousness.

There is a marked difference in the sorts of things feared at different ages, and the fears of boys and girls respectively, and it has been stated that the pre-school period is the most prolific of all for fear.

No childish fears should be left unattended to under the assumption that they will die out, as there is great danger of their forming the basis of an emotional complex with far-reaching results.

Watson's experiments demonstrated that children are not naturally afraid, but that fears are "conditioned" except those which are occasioned by loud noise or loss of support. An iron

bar was struck behind an infant at the same moment that a white rat was being shown him. After only a few repetitions and with an interval of days between the infant cried in fear and turned away from the white rat, and even from other white-furred creatures *without* any accompanying noise being introduced.

This reaction is known as "conditioned fear" and its baneful effects are apparent when we stop to consider that they "tend to modify or prevent, by limiting the number of objects which the child deals with, the formation of constructive habits."

**WILFULNESS IN CHILDREN.**—Hints of its existence in first year. Develops very quickly from the second year on.

Self-will in children may be caused by:

1. Physical failings.
2. Psychic causes, i.e., bashfulness and readiness to cry.
3. The feelings of distance between adults and the child. (Unsatisfied childish curiosity regarding the sexual difference between little boys and little girls, or between father and mother, and the incapacity to solve the problem may lead to fear of individual inferiority.
4. The arrival of a younger brother or sister without adequate explanation to the child. Like every living creature he responds with defensive action and practises self-assertion, which easily takes the form of self-will: whether active, re-active or passive.

**AMBITION** and craving for sympathy and applause.

No child really flourishes without the encouragement to renewed effort which praise and approval give. In his little way the child tries, by sounding his own trumpet, to present his small person in the right light.

Ambition may sometimes result in what appears to be wilfulness, and we must remember that self-will and rebellion are but the reverse side of

a very valuable quality, namely, the instinct for independence and self-assertion.

LOVE (including sexual or reproductive instinct).

In the later months of the first year can be seen the beginnings of sympathy and love, the first stirrings of a personal emotional tie binding the child to another human being. Normally this feeling continues to expand until the second and third year; conscious active altruism can be said to exist from then on: the child does make an effort to do the thing which will give pleasure, as when my small niece at 5½ years of age went out into the garden and picked a little nose-gay which she presented to me on my return after an absence for several months.

SEXUAL INSTINCTS.—Very intimately associated with the emotional development of the child are the manifestations and behaviour connected with the reproductive instinct. It is a subject upon which volumes have been written and upon which there is far from unanimity of opinion. Suffice it to say that the followers of Freud in the psychoanalytical field are inclined to the belief that the youngest infant is capable of so-called "onanie," and that there is a definitely sexual aspect to a babe's sucking movements and in the way in which it kisses its mother.

The important point, however, is to recognize that at a very tender age indeed children manifest curiosity with regard to the anatomical differences between boys and girls, and the how and why of birth. This curiosity should be satisfied *at once* for any attempt to sidetrack it or prevaricate is very likely to result in psychic disturbances of a serious nature in later life.

JEALOUSY.—One of the most primitive and painful emotions. In animals it appears in connection with mating, feeding and breeding and serves as a corrective to too great sociability.

Jealousy exists even in early childhood, but it differs most strongly from the erotic jealousy of a later age. In typical childish jealousy the claim to monopoly has reference only to demonstrations of affection, whether present or to come. Also the rivalry implied in jealousy makes no difference in the child's feelings of affection. Whereas in the adult any feeling of affection for an erotic sexual rival is an impossibility.

HATE, ENVY AND CRUELTY.

In childhood these do not seem to possess the strength nor the distinctly primitive nature of love. Hatred in a child is not a primary feeling but one derived from emotions of another kind first, amongst which is love. Even in an adult hate is in a great measure suppressed, disappointed love.

In children cruelty comes from ignorance. Their boundless desire for movement, their insatiable curiosity with characteristic disregard of consequences are all brought into play whether the object be a toy or a living creature. There can be no question of any conscious realization at the possible agony they may be causing.

The foregoing may be summarized by a quotation from Baldwin's preface to "The Emotions of Young Children," by Marsten:

"The result of experiments shows marked habitual emotional attitudes in children as young as two to three years of age, and the practical implication is that many pronounced tendencies which may later cause maladjustment of the child in social life are modifiable and subject to training during the earliest years."

A study of the emotional life of a child of pre-school age leads to the realization of its great importance and the obligation incumbent on all who have children under their care to understand how to use these most potent and vital forces to build up a strong and happy personality.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

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### *Training Public Health Nurses*

[The following was written by Dr. H. W. Hill, Professor of Public Health Nursing and Bacteriology; Director, Vancouver General Hospital Laboratories, as a foreword to the Public Health Nurses' Bulletin issued by the Provincial Board of Health, British Columbia.]

Training Public Health Nurses is a fascinating business, by no means yet brought to the point of classical perfection. Nor will it ever be brought to that point until public health itself is a finished product. This is equivalent to saying that training public health nurses will never be quite perfect, because public health never will be quite perfect. Even approximate perfection in public health is many a long day—years at least—centuries probably—ahead of us. Public health depends on every other science, and all sciences are yet imperfect—even mathematics. Public health depends also on human intelligence—we need hardly comment on its present state.

But the above considerations are just those which make public health today the most fascinating of all big business—because today we have the chance to build up, devise, design, direct to some extent at least, the development of public health at its most interesting stage. The heaviest, hardest, least organized, least co-ordinated work has, much of it, been done. The building-stones have, many of them, been more or less well hacked out; some of them have been more or less well fitted to each other. We may begin to see something of the ultimate thing we are erecting.

Leaving metaphors, the more we

know of public health, the better we can train public-health people in general and public health nurses in particular. Public-health knowledge is every day increasing. Our courses today cannot be what they will be ten years from today. But the public health nurse graduate of today will, ten years from now, have had not merely what training we can give her now, but ten years of that training which the big world has meantime given her—a training obtained not under university supervision, but under the nurse's own supervision. Our training is but the introduction to the larger and better, if rougher, training of the real world outside. Our most earnest desire is to so equip our graduates here that they will meet, equally and well, this rougher, sterner, more exacting training—will see in all their future work, not just a job, but a chance for study, for construction, for the pushing forward of public health from what it is to what it some day will be.

Observe, record, study, think out, all that you encounter, whether you are a non-graduate, an undergraduate, or a graduate. This applies to real life and to the more or less inaccurate reflections of real life that books or teachers give. If all of you do this, we need have no fears for the public health of the future.

## *School Nursing in London, England—(Concluded)*

By M. E. MISNER, R.R.C., F.B.C.N.

### III

#### NEW TOWN TREATMENT CLINIC

*Swain's Lane, Highgate Road*

This treatment clinic is operated by the London County Council, and was, perhaps, the most intensely interesting spot of the many centres visited. It was built and presented to the London County Council by a rich leather merchant in memory of his two sons killed in the war. In the clinic the two large wards are named Jack and Norman, respectively, after these two young men. The wards, bright and beautiful, and done in blue and white, are a happy residence indeed for the minor operation cases of children of school age. In one of these wards there is one private bed which anyone can use by paying ten and six a night, and there is also one private ward which can be had for fifteen shillings per night. Then there is a very large general waiting room and offices adjoining, a minor ailments department, consisting of a waiting room and treatment room and aural room, an eye-testing dark room, an ionization room, an anaesthetic room, a skin room, a bathing and treatment room, and a fumigating room. In the latter all the clothes worn by children on admission are fumigated by means of formalin tablets and a night light. In connection with the dental department there is a very interesting room known as the rinsing room in which a water shed sink running the length of the room and known as the "Physiological Sink" is in action during operations. As soon as a child who has had an extraction leaves the dentist's chair he is directed to the "Physiological Sink" to spit out. The water runs so swiftly over the watershed that the child has no opportunity to see the blood after it leaves

his mouth and so is not alarmed. As soon as he is ready to leave the child is sent out to the street by means of a private door, never being allowed to go back through the waiting room to disturb by bloody tales the dental cases there waiting their turn. One day a week is given to gas cases and a day to minor extractions, the rest of the week being given to stoppings and other treatments.

This clinic is known as a "Stay-in" clinic because of the bed accommodation for T. and A. cases. Wherever home conditions are so bad as to be a menace to the chances for recuperation following a tonsilectomy, the children are taken to a "Stay-in" clinic where they may stay for two days. Children under this category from other "Day" clinics are brought here. There are ten beds available, but cases are admitted in squads of nine, the one extra bed being kept free for fear some child may not be well enough to leave on the regular day. On the day of discharge the parents come early in the morning for the children. As soon as all the mothers and children are collected ready to depart, the Sister in charge lectures to the mothers. They are advised to have the patients rest for three or four days, to give no milk unless a very little in tea. They may have cold water, lemonade, but no other drinks. They may, however, have plenty of gravy, broths, beef blood, squares of toast and bovril, a little later some meat and stewed apples with sugar, but no bananas. The nurse is very strict about the milk. The beef and its juices are said to be very like what is already in the stomach (blood from tonsils) and therefore no disturbance, whereas milk would be disturbing. The children must be brought back to see the doctor in ten days' time. The doctors of this clinic never do a T. and A. on



a child who is menstruating, as there is a tendency to hemorrhage, nor on a child who has that peculiar redness of cheeks, excessive hardness and fatness of hips, or is undersized, or is late in having menstruation, as these symptoms point to thyroidism, and the child must be sent to the minor ailment department for thyroid treatment before being taken on for operation. In operating the guillotine method is always used.

Each "Day" clinic has a doctor and anaesthetist of its own who come to the "Stay-in" clinic for their own patients' operations. The "Stay-in" clinic has its own doctor and anaesthetist as well, who operate certain days. Minor ailments are those which need treatment but do not keep the children from school. There is an entente between the school and the clinic. The teachers finding anything wrong with the child promptly send him to the clinic at noon hour. At the minor ailment clinic, a list of children attending and the hour, is kept. This list is compared with the teacher's register. If the child is at the clinic at the school hour he gets his mark just the same. I listened to the Sister in charge lecture to a group of twenty student teachers one morning on detecting minor ailments and communicable diseases. These embryo teachers listened with deep interest and agreed to do their best to co-operate in all ways possible to safeguard the health of school children. The Sister showed them over the whole place as well, saying afterward to me that she thought it helped a great deal if the teachers knew and understood what the centre was and the reasons for and kinds of treatment.

Major ailments are those through which a child misses school. At the centre each ailment has a certain colour of card which the child must bring each time. The Sister does not need to ask the child why she is there, as the colour of the card tells to what department she is to go.

Ionization is given for running ears, that is for suitable cases, the large recent perforations being considered most suitable. A vulcanite speculum is used as it does not get hot. Some treatments cover a period of five years, I was told. Often cases appear to be cured, and the parents think they are, but there are not so many real cures after all.

Here Ultra Violet Ray is also given to suitable cases. The doctor selects the ones he thinks should have it. A course of ten general exposures is given, because by improving the general health, the ears are improved. The other treatment for running ears is a T. and A. operation, but many, many cases which would have developed into mastoid involvement are saved by ionization and sunlight treatment.

In the minor ailment department, otorrhoea is treated by peroxide first, spirits second, glycerine and carbolic third. Alum broth cotton is used for swabbing, as the nurse has to handle it and twist it for swabbing the ear. It is antiseptically treated and blue in colour. Mercer's Ear Channel is used with great success, as it never spills and is so easy to hold by the tiniest hands. It is conical in shape, the open end being very small.

On admission to the centre the child is equipped with a cap, nightie, kimona, and slippers, a tooth brush, hair brush, wash cloth, and soap, all on a little tray, one for each child.

The staff of this centre consists of one Sister in charge, six nurses on eight and a half hour duty, two of whom live in; of doctors, there is one surgeon, one anaesthetist, one minor ailment doctor, one eye specialist, and one aurist, but, besides these about fourteen doctors come in. There is one dentist and one organizer, and looking after the house there is a porter, his wife, and one maid.

Charges for medical and dental treatment are, one shilling for minor ailments after the first fortnight, two

shillings for other medical or dental treatment after the first fortnight, and these fees are good for six months.

The average cost to the London County Council of each case treated is:

Adenoids and enlarged tonsils .....	10s.	10d.
Minor ailments .....	7s.	7d.
Dental treatments .....	7s.	.....
X-ray of ringworm .....	25s.	7d.

#### IV

#### STOWEY HOUSE *An Open Air School*

I was privileged to make two visits to Stowey House, Clapham Common, one of the most famous of the open air schools—one day being spent in the company of the supervisor of school nurses for the boroughs of that vicinity and the other in the company of the superintendent and teachers. It was an astonishing thing to me to step through a small door in a high wall on a busy and closely built up street and find myself, after passing the house and kitchens, in a huge garden. The head master later complained that the open air school grounds are being encroached upon instead of expanding, owing to the greedy and commercially-minded people who own the surrounding property. Some of the lots adjoining the school grounds, which they had the privilege of using previously are being sold or fenced off. Even so, however, much good work is being accomplished. There are eight separate huts—each hut occupied by a class—five for boys and three for girls, and a large shed used for the daily sleep and for folk dancing and corrective exercises. These exercises are given in the form of the most beautiful dances, into which the teachers, pianist and pupils enter with utter zest and abandon, striving for perfection of beauty of movement and the improvement of health. The pupils also work in the gardens, build floors, platforms, walks, much

of the furniture and many of the appliances used at the school.

There are three hundred children on the roll of this particular school—this number being chosen by the Stowey House doctor from the fifteen hundred candidates sent up by the school medical officer each year. The pupils remain at the open air school one to one and a half years. They go home to sleep each night and over the week end, but the school is open the year round. The staff consists of the superintendent (who is very busy most days interviewing parents and guardians), a medical officer, a nurse, a head master, who also teaches, and seven other teachers.

A feature of Stowey House open air school is its sun classes, held on wooden platforms with no covering, the pupils wearing only a light loin cloth or very light and brief shorts. The results of these sun classes seem very satisfactory on the whole, there being various standards in gain in weight and height, but a universal and striking improvement in the vivacity, brightness and general alertness of the pupils.

Cases of anaemia are always cleared up in the sun classes, and in most cases enlarged glands subside. Out of a class of forty-two girls, nine and a half to twelve years of age, five exceptionally bad cases who were often absent from school for long periods did not improve; seven others suffering from malnutrition and enlarged glands showed little improvement, but the remaining thirty showed marked improvement in every way. Some children brown excessively, some normally, and some not at all. Others who are known as frecklers all seem to be children with enlarged glands which resist improvement. However, the sum-up of all observations in regard to browning is that the amount of browning does not always indicate the amount of improvement in physical condition.

Here also must be mentioned the Rachel McMillan Camp School for

children aged two to five years, of which a whole story could be written. It is enough to say that nursery schools have been in existence in London since 1908, the McMillan School being opened in 1911. In the beginning of 1917 the school medical officer presented a report to his committee pointing out the advantages in poorer neighbourhoods of school attendance in the control of infectious disease, and the particular benefit of nursery schools under the care of an experienced matron who would take advantage of existing clinics and institutions. During the same year a conference including education officers, head-mistresses and medical officers, was appointed to report on the education of children under five. As a result, in 1918, the Education Act gave powers to local education authorities to aid in the supply of nursery schools for children two to five years of age, and to attend to their health, nourishment and physical welfare. In 1919 eight voluntary nursery schools were recognized by the Council. In December of that year the school medical officer advocated daily visits to these schools by school nurses. In 1920 the Council decided, after much discussion and changing of plans, not to proceed with the establishing of the proposed six additional nursery schools, but to support the Council's portion of the Rachel McMillan School. In 1923 Doctor Hogarth reported on the effect of nursery schools on the health of children. The children leaving the nursery schools to enter the infants' department of the elementary schools, were found to be superior to the ordinary entrant. At the Rachel McMillan nursery school the weight of the six year old child was appreciably greater than that of the six year old who had been attending an elementary school in the same neighbourhood for three years. With an average attendance of two hundred and twenty the Rachel McMillan School is found to have no larger

percentage of communicable diseases occur than the schools of from twenty to fifty children. A marked improvement in the whole physical and mental state has been noticed in this school also. One of the most remarkable results from a medical standpoint is the reduction in the prevalence of catarrhal conditions of the respiratory tract and its injurious results, proving beyond a doubt that during the child's attendance in the school he has not only acquired resistance to disease, but very marked recuperative powers. Breathing exercises, massage, and sunlight treatment are given where necessary, and the nasal catarrh, so prevalent among these children on admission, clears up rapidly in these hygienic surroundings. Skin disease is almost unknown there, too. Sir George Newman says, "I am of the opinion that the nursery school is conducted on sound health principles, that it forms the foundation of permanent good health; that it fulfils with conspicuous success the purpose for which it was established."

Children referred for tonsils and adenoids in the ordinary elementary schools this year formed 5.5 per cent. of the whole, most of these being infant entrants, amongst whom the greatest proportion of diseased throat conditions is always found.

Infant entrants are the greatest sufferers in lung disease, other than T.B., also the condition nearly always is bronchitic, with slight or greater rickets, the larger percentage of these cases being boys. T.B. is found in the entrants; therefore, almost none is found in the standards or grades. The dental condition of entrant infants seems always to have been about the same; 46 per cent. have manifest dental caries, and 15 per cent. caries with inflamed and septic gums. Dental inspection and treatment at school have much improved the oral conditions of older children, but this is all remedial work and only in a minor degree preventive. The remedy, as the English medical

authorities see it, is to get in closer touch with the mothers while the children are still infants, and teach them how to feed their children properly at a very early age.

One striking thing to me in the English people is the almost total lack of enlarged thyroid gland in both adults and children, Derbyshire being the only place where it is found. The other very striking thing is the prevalence of rheumatism in children. It now takes first place as the cause of chronic illness in childhood, and is the only widespread menace to the school child's health which is not being appropriately dealt with. T.B. used to be the greatest menace, but such good administrative measures have been passed and applied, that now only 12 per cent. chronic illness is due to it, while rheumatism accounts for 24 per cent.; whereas it used to be 20.5 per cent. T.B. and 14.5 per cent. rheumatism.

In ear testing the school doctors are instructed that the acuity of hearing should be as nearly correctly estimated as possible. The forced whisper should be used, and the distance used for the tests should be entered on the medical record card. The forced whisper should be made at the end of an ordinary expiration. Numbers like ninety-seven, eighty-three, etc., or words, such as banana, potato, or tobacco, may be used. The child should not be in a position to watch the doctor's lips, and should be requested to repeat the words heard. One ear is closed while testing the opposite ear.

A. A child who responds to the test at twenty feet should be considered normal.

B. One who responds at between six and twenty feet, slightly hard of hearing (to be watched).

C. One who responds, in the better ear, only at distances less than six feet should be considered hard of hearing or deaf.

All children falling into this last category should be nominated for special examination with a view to having them sent to the hard-of-hearing classes. The hearing test is ordered to be given as early as possible in the child's school life, so the loss of time and learning will be minimized, because the earlier he is put into the special hard-of-hearing class the better he will do. Much to my astonishment, I saw that cases of otorrhea numbered only 1.4 per cent., but because a good deal of my time had been spent in treatment centres, where I saw, what seemed to me, endless cases being treated, I got the impression that the trouble was very prevalent. They are tedious cases and take much time, but most excellent results are being obtained by artificial sunlight and ionization. In the former treatment as carried out in the Minor Ailment Department at St. George's Dispensary in the borough of Southwark, the ear is cleaned with soda bicarb, a spirit plug inserted, and the child taken to the sunlight room. The child is stripped, a pair of very flimsy and tiny tights and an eye-shade adjusted, a large piece of brown paper is perforated in the centre, and through this perforation a speculum is put, and inserted in the ear, and down this canal are directed the ultra violet rays from a Tungsten Arc Lamp. General as well as local ultra-violet ray treatment is given in all cases, it being considered that in toning up the general system local conditions improve more rapidly. The back is given three minutes at a distance of two feet; the ear three minutes at ten inches distance, the first day; on the second day one minute is added to the back and half a minute to the ear. Each treatment is increased accordingly until an eight-minute period is given, when the treatment starts over again. A powder treatment is given following the light treatment. After the trouble is cleared the treatment is continued



in minimized doses and as a precautionary measure. The ionization method is not used at St. George's, but is mentioned in my report of the Highgate Clinic. At St. George's four nurses work at top speed several hours of the day dressing the wounds and sores, etc., of school children. In the afternoon from two to four a doctor attends and holds a toddlers' clinic. Upstairs wards are being prepared to accommodate stay-in cases of T. and A. operated on there.

All children on sun treatment are weighed once a week. It was thought that during treatment great increase of weight should take place. It has been proved that this is not so. The weight varies during treatment, but after cessation of treatment increase is noticeable. In very young children, ringworm of the scalp is sometimes treated, because X-ray treatment seems hard for them to take, but most cases of ringworm are treated by X-ray because it is much quicker.

There has been a gradual increase in the number of children reported with enlarged glands, especially among the beginners; the incidence is heavier among boys than girls, and this comparison holds among older children as well. Since no larger number, however, are being referred for treatment, it is thought that the apparent increase is due to doctors notifying to a greater extent the slighter degrees of enlargement.

Defects in vision are somewhat more prevalent among girls than boys, but there is a distinct improvement in all. Owing to the excessive amount of visual defect amongst Jewish boys, co-operation has been

sought with the Jewish Health Organization of Great Britain, for better supervision, particularly as regards Jewish classes in the evenings.

There has been a rapid decrease in the cases of rickets, and again boys are the chief sufferers, as they always are, in this condition. It is now suggested that the incidence of adenoid growths and enlarged tonsils is chiefly among children who have suffered from rickets in infancy.

More and more it is borne in upon us that preventive work must be started and carried on extensively among the very young, long before they come to school.

The survey of statistics and records shows that each year the older children are leaving school with fewer and fewer defects. Many there are, of course, who leave with still existing defects, but most of these are due to causes over which the schools can have no control. These causes operate most profoundly also upon the infant child in its pre-school years. The school medical service is the receiver of damaged goods, and spends most of its time and energy patching them up. What is now required is an intensification of effort directed to the care of the infant in arms and the toddler of pre-school age, so that children will come to school in the beginning with constitutions unimpaired and with bodies attuned to receive the mental, moral and physical education which it is the function of the schools to impart.

All pupils at secondary and technical institutions are seen by the school medical officer annually.

## News Notes

### ALBERTA

At a recent meeting of the Nursing Education Section of the Alberta Association of Registered Nurses a plan was approved whereby subsection meetings shall be held every two months at Edmonton, Calgary, Medicine Hat, Lethbridge, High River, Camrose and Lamont. The convener of each subsection will be required to report to the secretary of the Section any matters which should be brought to the attention of the Section in general meetings. This plan is being adopted in order that members of the Section may be brought together in these centres which are at considerable distance from one another. The widely scattered areas is one of Alberta's special problems.

**CALGARY:** A largely attended monthly meeting of the Calgary Association of Graduate Nurses was held in the Public Library on November 19th. Miss Spreckly gave a most interesting lecture on "Massage."

Miss S. MacDonald, lady superintendent of the Calgary General Hospital has returned after a two months' vacation in the East.

Miss A. Stone has resumed her duties after a long vacation spent in Ontario.

Miss L. Barre, who recently underwent an operation, has recovered, and has resumed her duties as matron of the Innisfail Municipal Hospital.

Miss R. Boyd has been appointed matron of the Blackie Municipal Hospital.

Misses Grotte and Roane have left for North Dakota, owing to the illness of Miss Grotte's mother.

### BRITISH COLUMBIA

**VANCOUVER:** The November meeting of the Vancouver Graduate Nurses Association was held at the Nurses' Home, St. Paul's Hospital, Miss May Ewart presiding. After the routine business was finished a delightful entertainment was given by the nurses of the training school and the members of St. Paul's Alumnae. At the close of the meeting refreshments were served by St. Paul's Hospital. A hearty vote of thanks was extended to all who contributed to the success of the evening. For several years the November meeting has been in charge of St. Paul's Alumnae, and the large attendance at this meeting proved the popularity of the event.

### MANITOBA

The annual meeting of the Manitoba Association of Graduate Nurses is being held on Friday, January 18th, 1929. The principal business to be presented is the proposed amendments to the Act for the Registration of Nurses in Manitoba, which are to be brought before the approaching Legislative Assembly. Every member is urged to attend this important meeting of the provincial association.

In September, 1929, it is planned that the M.A.G.N. shall meet in conjunction with the Manitoba Medical Association and the Manitoba Hospitals' Association.

At the annual meeting of the M.A.G.N. Miss Florence Robertson gave a most interesting talk on the International Conference of Social Work, held in Paris this past summer. Miss Robertson represented the Social Workers of Winnipeg.

**BRANDON:** The regular monthly meeting of the Graduate Nurses Association met at the Mental Hospital. Mrs. A. V. Miller, president, gave an interesting account of the C.N.A. general meeting held in July. A social hour was enjoyed during which refreshments were served.

Miss M. Stothard of the Provincial Board of Health is conducting the annual course of instruction and examination in the Normal School.

Miss Kathleen Aikens (Winnipeg General Hospital, 1928), has accepted a position on the staff of the Brandon Mental Hospital.

Dr. Glen Hamilton of Winnipeg gave a most interesting lecture on "Psychical Research" at the Brandon Mental Hospital on December 3rd. The meeting was very well attended.

### NEW BRUNSWICK

**SAINT JOHN:** The regular meeting of the Saint John Chapter of the N.B.A.R.N. was held in the lecture room of the Nurses' Home, General Public Hospital, on November 19th, 1928. Following the business session, Miss Maude Retallick, secretary-treasurer and registrar, N.B.A.R.N., gave an interesting report of the general meeting, C.N.A., at which Miss Retallick attended as representative for the province of New Brunswick. She stressed the need of support by nurses to the only national nursing journal in Canada, *The Canadian Nurse*, and urged that new subscriptions be solicited and renewals made promptly. A hearty vote of thanks was tendered Miss Retallick.

**GENERAL PUBLIC HOSPITAL:** At the regular monthly meeting of the Alumnae Association, held on November 27th, 1928, Miss Kathleen Lawson gave her report as a delegate to the annual meeting of the N.B.A.R.N. held in St. Stephen. Plans were made for a bridge to be held on January 6th, 1929, in the Nurses' Home.

### NOVA SCOTIA

**HALIFAX:** Graduation exercises were held at the Children's Hospital on October 4th, 1928, when diplomas were presented to: Misses Bertha Lowe, Marie Neilson, Elizabeth McDonald, Vera Smith, Ethel Smith, and Messrs. Thomas Nelson, Harold Murphy and Gerard McNeil. Miss Bertha Lowe received the DeWolfe medal for the highest average during the three years; the Medical

prize was awarded to Miss Marie Neilson; the Surgical prize to Harold Murphy, the Practical prize to Thomas Nelson. Misses Mae Boutillier and Catherine Grant were awarded the Junior prizes.

Miss Mabel Brown resigned her position as night supervisor of the South Building, and left for her home in New Ross on December 15th.

Miss Bertha Lowe resigned from her position on November 30th.

On October 8th, at the Dalhousie Public Health Centre, the Halifax Branch of the N.S.R.N.A. started the winter session meetings. Miss Jean E. Browne, Director, Junior Red Cross for Canada, as the speaker of the evening, gave the nurses an interesting account of the anticipated gathering which will be held in Montreal in July, 1929, when the sixth international congress of the I.C.N. takes place. At the conclusion of Miss Browne's talk, Miss Catherine Graham extended a vote of thanks to the speaker and presented her with a basket of flowers.

### ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in December, 1928, were 1,183, ten more than previous month.

#### APPOINTMENTS

The following appointments have been made:

Miss Dorothy Pitt (St. Joseph's, Hamilton, 1928), dietitian, St. Joseph's Hospital, Hamilton.

Miss F. Fish (Hamilton General Hospital, 1923), Mount Hamilton Hospital.

Miss H. Fowlds (Grant Macdonald Hospital, Toronto, 1925), nurse-in-charge of the hospital in connection with the Ontario Odd Fellows Home, Toronto.

Mrs. C. Ash (Grant Macdonald Hospital, Toronto), assistant instructor of preliminary and junior nurses, G.M.H.

Miss Grace Turnbull (Brantford General Hospital), the Henry Ford Hospital, Detroit.

Miss Reta Hawkins (Brantford General Hospital, 1927), supervisor of the private wing, B.G.H.; successor to Mrs. Houlding.

Miss Hilda Muir (Brantford General Hospital, 1927), supervisor of the Medical wing B.G.H.

Misses Maud Shuttleworth and Essie Kane (Toronto Western Hospital, 1924), outpost duty at Thessalon and Lion's Head, Ontario, respectively.

Miss Elaine Playle (Toronto Western Hospital, 1927) succeeded Miss L. Stacey (1925) as industrial nurse with the Canadian Carbon Company.

Miss Hazel Reid (Grace Hospital, Toronto, 1928), has been appointed as charge nurse in Grace Hospital.

Miss Margaret Reid (Grace Hospital, Toronto, 1922), has received an appointment at the Red Cross Hospital at Thessalon.

Miss Ann MacGregor and Miss Florence M. Thorpe (Grace Hospital, Toronto, 1926), have recently been appointed on the staff of Rockefeller Hospital, New York City.

Miss Gertrude Evans (Hospital for Sick Children, Toronto), ward instructor at the Queen Alexandra Solarium for Crippled Children, Malahat Beach, B.C.

Miss C. Hoeflin (Hospital for Sick Children, Toronto), instructor of the children's wards, the James Whitcombe Ryley Hospital, Indianapolis.

### DISTRICT 2

GENERAL HOSPITAL, BRANTFORD: On November 3rd, His Excellency Viscount Willingdon visited the General Hospital. The Vice-Regal party was welcomed by Mr. F. F. Revelle, chairman, and other members of the board, Mayor Beckett, Miss McKee, superintendent, and Miss Helen Potts, assistant. The nurses in training formed a guard of honour. In the children's wing each little patient able to hold one had a miniature Union Jack. His Excellency was interested in and fascinated by the triplets: Norma, Margaret and Betty Mars. He voiced many cheery words to the little sufferers and praised greatly all that he had seen.

The regular monthly meeting of the Alumnae was held in the Nurses' Residence on November 6th, with Miss Dora Arnold, president, in the chair.

The members of the supervisory staff were guests at a dinner given by Miss McKee, superintendent, in honour of Mrs. Houlding, who has resigned from the staff. A presentation of Sheffield candlesticks was made to the guest of honour.

Miss Chute has been ill for several weeks. It is hoped that she will soon be able to resume her duties.

Miss Violet Van Valkenburg is a patient in the General Hospital.

Miss Pearl Cole and Miss Margaret Collyer left for Bermuda early in December.

### DISTRICT 4

GENERAL HOSPITAL, ST. CATHARINES: Miss Gladys Ridge (1927) has returned from New York, where she has been charge nurse in the Babies' Hospital.

Miss Gwendolyn Morton (1927), is taking a post-graduate course at the Hospital for Sick Children, Toronto.

Miss Margaret Jackson (1928) is attending the Bible School in Toronto.

Miss Helen Brown (1928) is taking the course in Administration and Teaching in Schools of Nursing, University of Toronto. Miss Brown was awarded the scholarship offered by Col. and Mrs. Leonard.

The death of Miss Jessie McIntosh (Mack Training School, 1882) occurred on October 25th, 1928. Miss McIntosh was born at Dundee, Scotland, in 1848. Four years after graduation she received an injury to her hip which produced a permanent lameness, in spite of which Miss McIntosh nursed until 1925. Burial was made in Addington, Ont.

ST. JOSEPH'S, HAMILTON: The Alumnae social activities for the year began on October 13th with a delightful bridge, when fifty dollars was realized for Christmas Cheer for St. Mary's Orphanage.

Miss Margaret La Hiff (1918) died at her home in Hamilton after a long and painful illness. The funeral mass was held at St. Mary's Pro-Cathedral on October 20th, when some forty nurses formed a guard of honour as the casket was brought to and taken from the church. Miss La Hiff's quiet kindness will long be remembered.

The deepest sympathy of the Alumnae is extended to the Misses Quinn and Dwyer in the loss of their mothers.

A Requiem Mass was sung on November 26th at St. Patrick's Cathedral for the repose of the souls of deceased members of the Alumnae.

Sister Monica and Sister Savior are taking the course for Teaching and Administration in Schools of Nursing at Toronto University.

Miss Ivy Hoyle left on November 16th with her mother to spend several months in England.

The Misses Cornaford and Scully have gone to Olyean, N.Y., to help in the typhoid epidemic.

GENERAL HOSPITAL, HAMILTON: Miss M. Carter (1922) has resigned as operating room supervisor at the Metropolitan Hospital, Walkerville.

Miss Evelyn Swayze (1922) has resigned as supervisor of the Out-door Department, H.G.H.

#### DISTRICT 5

Ontario nurses lost a good friend in the death on October 13th, at the Wellesley Hospital, Toronto, of Miss Avarine Maude Evans, a former superintendent of the Toronto Graduate Nurses' Club, and sister of the late Mrs. R. B. Johnston, of Sault Ste. Marie, and of the Misses Isabel Lount Evans and Ethel Coulthard Evans, all graduate nurses.

Miss Evans was a descendant of United Empire Loyalist stock and was born in Toronto. She spent most of her childhood at Niagara-on-the-Lake, returning to Toronto in 1916 to take charge of Spadina Lodge, Spadina Avenue, resigning this position to assume the superintendency of the Toronto Graduate Nurses' Club, which position she held for nine years.

GRANT MACDONALD HOSPITAL, TORONTO: The Alumnae Association held a successful tea on November 24th, in connection with the sale of work by the Occupational Therapy Department. Part of the proceeds from the tea are to be contributed toward the I.C.N. Congress Fund.

Misses K. Murchison and J. Macpherson (1928) are enrolled in the course for Administration and Teaching in Schools of Nursing, University of Toronto.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Annie Ingham (1921) has returned to Toronto after a year's travel abroad.

ST. JOHN'S HOSPITAL, TORONTO: The following is the fourteenth annual report of the St. John's Hospital Alumnae: Six meetings of the Association were held during the year, the average attendance being ten members. Five new members were enrolled.

Six bridge parties were held at the homes of various members for the purpose of raising

money. These were successful as well as enjoyable.

Miss Hiscocks represented the Alumnae at the Chatham Convention, and her account of the meeting was most interesting.

Ten nurses received their pins and diplomas on Graduation Day. A few days previous to the Exercises, the Alumnae entertained the graduating class at dinner at the Professional and Business Women's Club.

Interesting and instructive lectures were given by two of the staff doctors at the February and April meetings.

GENERAL HOSPITAL, TORONTO: Miss Mabel Platt (1920) has left for her home in England, and is in residence at The Parsonage, Gretton, Cheltenham, Gloucestershire.

WESTERN HOSPITAL, TORONTO: The monthly meeting of the Alumnae Association was held in the Nurses' Residence on November 13th, and was very well attended. Professor McPhee of the Department of Psychological Research, University of Toronto, gave a very interesting and comprehensive lecture on the need of psychological knowledge for nurses. Professor McPhee stated that the nurse, in her eagerness to carry out therapeutic measures as directed by the physician, neglected or lost sight of the many underlying factors responsible for the patient's complete recovery. He said the nurse with her tradition and training should be well fitted to deal with her patient from the point of view of the social worker, as any human being who is physically ill is also mentally ill, and in most instances requires sympathetic and skilled help in the process of re-adjustment. In the past the social dilemma of the patient was the problem of the philanthropist who had his own simple way of giving help; this method was succeeded by that of the trained social worker. However, it is Professor McPhee's opinion that the nurse is better fitted than either of these to do this work.

A vote of thanks was tendered to the speaker for his most excellent discourse by Miss Beamish.

GENERAL HOSPITAL, TORONTO: A variety of attractive work was displayed at the sale in the Nurses' Residence on November 29th, under the auspices of the Occupational Therapy Committee of the Social Service Association of the Toronto General Hospital. Leather bags and purses, painted wooden boxes, knitted wear, handsome basketry and book ends, all done by hospital patients were exhibited, and a steady throng of people came to buy. The proceeds of the sale will be used to buy more materials. Tea was served in the dining room where Mrs. F. N. G. Starr, Miss Mortimer Clarke, Mrs. Frank Ralph, Mrs. A. E. Gooderham and Mrs. W. R. Riddell presided. Miss Des Brisay and Miss Jakes are the two workers in charge of the Occupational Therapy Department of the hospital.

A most enjoyable bridge was held in the Nurses' Residence by the Alumnae at the regular meeting on December 5th. The



business of the meeting was short, but very interesting. A letter was read from Miss Snively in appreciation of her birthday gift of a dressing gown and accessories from the Alumnae, and thanking the members for remembering her. The sum of twenty-five dollars was voted to be given to Miss Jean I. Gunn towards the Outdoor Christmas Tree Entertainment. A motion was passed to hold only three general meetings of the Alumnae during the coming year, the annual one in January, the second in the spring and the final one in the fall. Miss Gretta Ross is in charge of a committee to arrange for a group of lectures by doctors, and suggestions for these may be sent to her at once. Miss E. Manning, who was in charge of the arrangements for Theatre Night, which was held in October at the Royal Alexandra, when the D'Oyly Carte Opera Company presented "Ruddigore," reported that the undertaking was a success, and that the Alumnae's objective in funds for the I.C.N. had been reached. At the close of the evening refreshments were served.

Miss Margaret Dulmage (1918), has been granted a Rockefeller Fellowship, and is at present taking special courses in Clinical Teaching and Public Health Nursing at Yale University.

Miss Ruth Carhart has returned to New York and is again on the staff of the Rockefeller Hospital.

Miss Sylvia Ooster (1922), has left Hornpayne, Red Cross Outpost, and is starting a new outpost at Bracebridge, Ontario.

Miss F. Van Duzer (1922), has left Detroit and is doing private duty nursing in Toronto.

Miss R. Goddard, of Imperial, Saskatchewan (Rae Amey, 1922), was visiting in Toronto recently.

Miss Charlotte Gardner (1922), who has been at her home in Owen Sound, has returned to New York where she is engaged in private duty nursing.

Miss Olive McNee (1922), has left the Women's Hospital, Cleveland, Ohio, where she was doing operating room work, and has gone to St. John's Riverside Hospital, Yonkers, New York, to do floor duty.

GRACE HOSPITAL, TORONTO: Miss Hilda Duckworth (1927), resigned her position as charge nurse in Grace Hospital, to engage in nursing work in India. The medical and surgical staff of the hospital presented her with a handsome covered travelling-bag; the graduate staff gave her a travelling rug, and the Grace Hospital Women's Auxiliary, a week-end bag. Miss Duckworth left on November 22nd for England to enroll with the British College of Missionary Students, under which organization she will work.

The Grace Hospital Alumnae held a very successful bridge on November 28th, at Sherbourne House Club. One hundred and fifty people were present, among them many of the older graduates.

HOSPITAL FOR SICK CHILDREN, TORONTO: The authorities of the University of Toronto and of the Hospital for Sick Children have arranged to include two students of the

training school, H.S.C., in the four year course in Public Health Nursing. One student was enrolled for the fall term, 1928.

Miss Kathleen Pantton has resigned as superintendent of nurses, H.S.C., and has returned to her home at Milton. Before leaving, she was the guest of honour at a large reception in the Nurses' Residence, given by the Board of Trustees, when she was presented with beautiful flowers and a platinum wrist watch set with emeralds and diamonds, a gift from the medical staff. The watch matched a beautiful brooch previously presented by her nurses. Other presentations made were a travelling bag from the administrative staff, and a silver jewel bag from the dietitians and masseuses. Among farewell parties to Miss Pantton was a dinner at the Granite Club, when the staffs of the city hospitals acted as hosts.

#### DISTRICT 7

The regular meeting of District No. 7, R.N.A.O., was held on November 9th, at St. Joseph's Hall, Hotel Dieu Hospital, Kingston. There was a splendid attendance; Brockville, especially, was well represented. Miss Acton, president of the District, was in the chair. The Reverend Father Dr. O'Gorman, of Ottawa, gave an interesting and inspiring address. His subject was "Early Founders of Hospitals in America," and he emphasized the part the Spaniards and the French played in the introduction of civilization and culture in America. Father Nicholson gave a few words of encouragement to those present, after which Dr. Wm. Gibson gave a very interesting paper on "Microbe Hunters". The business meeting followed. The reports from the different sections were very encouraging. After the adjournment of the meeting, the Alumnae of the Hotel Dieu were hostesses at high tea, in the reception room of the Nurses' Home.

HOTEL DIEU HOSPITAL, KINGSTON: The Alumnae of the Hotel Dieu Hospital recently held a Rose Tag Day, when the sum of seven hundred dollars was realized.

Miss Agnes Ryan (1923), who took a post-graduate course in the New York Eye and Ear Infirmary, is now doing special duty in the same institution.

Miss Millie Cook (1923) is taking a much-needed rest in the Adirondacks.

Dr. and Mrs. F. Hamilton (Aileen Cooper) and baby daughter visited Kingston recently.

Sincere and deep regret was felt by all members of the Alumnae upon hearing of the untimely demise of Miss Florence Byrne. She graduated with honours in 1920, after which she did private duty in Syracuse, N.Y. Later she accepted a position in the Ohio Valley Hospital, Steubenville, Ohio. Afterward she returned to her home in Perth, where she continued her professional duties until December, 1926, when she contracted a disease of the lungs. Following an illness of eighteen months, she died at her home on July 18th, 1928.

At recent meetings of the Alumnae Miss M. McKinnon (1922) gave an interesting account of her travels through China, under

armed escort, and Miss Louise Acton, instructor of nurses at the Kingston General Hospital, gave an instructive address on the work of the R.N.A.O.

Miss Gertrude MacLean (1927), who is on the staff of the Willard Parker Hospital, New York, is spending a month at her home in Kingston, a convalescent from a severe attack of diphtheria.

Miss Gertrude McCullough and Miss Gladys Lutz (1925) are doing general duty at Nyack Hospital, Nyack, N.Y.

#### DISTRICT 8

The regular fall meeting of District No. 8 was held on November 28th, at the Nurses' Home of the Ottawa Civic Hospital. The attendance was excellent, and the programme throughout the entire day one of great interest. Miss Gertrude Garvin, superintendent of Nurses, Strathcona Hospital, and chairman of the District, presided over the sessions.

During the morning, after routine business was disposed of and a report of proceedings at the C.N.A. meeting at Winnipeg had been read, excellent demonstrations were given, on "Infant Feeding," by Miss Moore, assistant dietitian of the Civic Hospital, on "Ear, Nasal and Colon Irrigations" and "Hair Shampoo" by Miss Eleanor Grew, practical instructor at the Civic Hospital. Miss Grew and Miss Tanner also gave a demonstration on methods of urinalysis.

Through the courtesy of Dr. D. M. Robertson, superintendent of the Civic Hospital, and the Board of Trustees, a very enjoyable luncheon meeting was held at which Dr. J. A. Amyot, deputy minister of Health, gave an address on the timely subject, "A Pure Water Supply for the City of Ottawa".

During the afternoon session Miss Florence Emory, president of the R.N.A.O., gave an address, rich in interest and inspiration, on the subject, "Professional Organization".

Miss Emory was followed in her address by Dr. Sheriff, superintendent of the Strathcona Hospital, who gave an illuminating and instructive paper on "Immunization".

The responsibility of Ottawa nurses in connection with the coming I.C.N. Congress in Montreal was clearly and forcefully dealt with by Miss Gertrude Bennett, superintendent of nurses, Ottawa Civic Hospital. Miss Bennett also recommended very highly to those present Dr. Burgess' book, "Nurses, Patients and Pocket-books."

An interesting feature of the programme was the splendidly arranged exhibit, including various treatments and diet trays, teaching models, and samples of current nursing journals.

Miss Mabel Williamson, sister of the late Miss Janet Williamson, has resigned from the staff of the Strathcona Hospital, and intends spending some time with her brother, A. P. Williamson, Esq., 2121 31st St., Seattle, Washington, U.S.A.

#### DISTRICT 10

The November Meeting of District 10, R.N.A.O., was held in the Nurses' Home, Port Arthur General Hospital. Thirteen

nurses were present. Final arrangements were made for the Annual Bazaar.

Rev. Dr. Patterson gave a very interesting address on "Hitch Your Wagon to a Star". Following a musical programme, lunch was served by the Hospital staff.

St. Joseph's Hospital Alumnae, Port Arthur, entertained at a tea and sale of work in the Nurses' Home, November 10th. The proceeds amounted to \$100.00. The Alumnae are furnishing a ward in the new wing of the hospital.

McKellar Hospital Alumnae regular monthly meeting was held November 27th at the home of Mrs. F. W. Edwards. Twenty members were present. An instructive and interesting paper on "Tannic Acid Treatment for Burns" was given by Miss Florence Hamm, school nurse in Fort William. Following this whist was played and lunch served by the hostess.

#### QUEBEC

GENERAL HOSPITAL, MONTREAL: Appointments made recently among members of the Alumnae are: Miss Edna Shaver (1928), to the S.O.R. staff Woman's General Hospital, Westmount; Miss Doris Stevenson (1928), in charge of the operating room, Children's Memorial Hospital, Montreal; Miss Ina Currie (1924), to the staff of the Shriners' Hospital, Montreal; and Miss Dorothy Driffield (1927), to the staff of the Victorian Order of Nurses, Montreal.

Miss Alice Isabel Wells (1928), passed with highest honours in the recent examination for registration of nurses in the Province of Quebec.

The engagements are announced of Miss M. Joyce Hervey (1928), to Mr. Owen Evans, Round Hill, N.S., and Miss Alma Adams (1919), to William J. Foley, Ottawa.

Mrs. Huggins (nee Janet McNabb, 1920), and her husband, who were missionaries in Central Africa for a number of years, are now living in Kingston, Ontario, where the latter is attending Queen's University.

The sympathy of the members is extended to Misses Christina, Gertrude and Helen Arnoldi in the loss of their mother; Miss Dorothy Jones, her father; Mrs. Neale (nee Juliana Stewart), her father; and Miss Ruth Hamilton, her two sisters.

Misses Winnifred Kirkham and Betty Smith (1927), spent the summer at Miss Kirkham's home in Jamaica, visiting Bermuda en route. The former is now doing private duty nursing in Montreal, and the latter is in charge of a ward at the Shriners' Hospital, Montreal.

WESTERN HOSPITAL, MONTREAL: The Alumnae held a very successful bazaar on December 1st, 1928, in the Nurses' Residence.

Miss Marian Nash has recovered from a short illness.

HOMOEOPATHIC HOSPITAL, MONTREAL: Graduation exercises were held in the Nurses' Home on November 23rd, 1928. Eight nurses received their medals and diplomas. They were the Misses M. R. Sleath, E. M. Ashby, M. O. Berry, C. Mason, H. Kennedy,

J. Coyle, W. Murphy and E. Terry. Miss M. O. Berry received the Honour Pin. Refreshments were served at the close of the exercises. In the evening a dance was held and enjoyed by the nurses and their friends.

**GRADUATE NURSES' ASSOCIATION OF THE EASTERN TOWNSHIPS:** The deepest sympathy of the Association is extended to Mr. George MacKinnon and daughters in the loss of a loving wife and mother. Mrs. MacKinnon was a graduate of the Mount Sinai Hospital, N.Y., and was president of the G.N.A. of the Eastern Townships for two terms. Mrs. MacKinnon was loved by all, and her loss is very keenly felt. Her place can never be filled.

Miss Norah Arguin has returned from a two months' vacation in Ottawa.

Miss Ella Morrisette returned from a holiday with her brother at Iroquois, Ont.

### C.A.M.N.S.

**SAINT JOHN:** A most enjoyable dinner bridge was given by the Overseas Nurses' Club on November 12th, at the home of Miss Lyla Gregory. Following a delicious dinner toasts proposed: were "The King"; "Our Comrades"; and "Mrs. Gregory," the hostess' mother. Misses Burns and Campbell won the bridge prizes. A short business meeting was held afterwards, and the following officers elected: President, Miss Agnes Sutherland; Secretary, Miss Ethel M. McMillan; Treasurer, Miss Lyla Gregory.

On November 30th, 1928, the Overseas Nurses' Club held a well-attended bridge in the Recreation Hut of Lancaster Hospital in aid of the benevolent work among returned soldiers' families. The conveners of arrangements for the evening were Mrs. Scott, Miss Gregory and Miss Cambridge.

**WINNIPEG:** The annual Armistice Tea of the Nursing Sisters' Club was held in the Marlborough Hotel on November 10th. The guests were received by the president, Miss Edith Hudson, and the following assisted: Mrs. E. Horton (N/S Margaret Kennedy), Mrs. Hambly (N/S Leslie), Mrs.

C. W. Davidson (N/S Hilda McColm), Miss McGillvary, Mrs. Gordon Cooper (N/S Janet Smith), Mrs. A. D. McLeod, Miss Mamie Johnson and Miss Letellier. A letter was read from Mrs. J. Parker (N/S Waughn), who had recently left the city to reside in Saskatoon. Her many friends were pleased to learn that she was getting settled in her new home. An invitation was read from the president of the Deer Lodge Hospital Branch of the Canadian Legion, B.E.S.L., in which the nursing sisters were invited to join their Branch, and to then become the Nursing Sisters' Section of that Branch. This question will be taken up at the annual meeting. Twenty-two members of the Club have already become members of the Deer Lodge Hospital Branch of the Legion. The local Club would be interested in hearing what action other Clubs are taking in this matter.

Mrs. Charles Greenwood (N/S Myrtle Jephson), of Edmonton, accompanied by her children, is spending a few weeks in Winnipeg with her mother.

### VICTORIAN ORDER OF NURSES

Miss Rebecca MacLennan is relieving on the staff in Sydney, N.S.

Miss M. Isabelle Argue has resigned from the staff in Lachine, Quebec. Miss Argue has accepted a position with the Dominion Bridge Company.

Mrs. M. Macdonald has been appointed to the staff in North Vancouver.

Miss Germaine Dumais has taken the position left vacant by the resignation of Miss Marguerite Pauze from the staff in Cornwall.

Miss Helen Lemke has resigned from the staff in Galt to be married.

Mrs. Rena Moseley has been appointed to the staff in Hamilton.

Miss Rose Nye, of Pembroke, has been granted leave of absence. Miss Bessie Sweeney will be in charge of the Pembroke district during Miss Nye's absence.

Mrs. Jessie Drain has been appointed to the staff in Stratford.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

**BABCOCK**—In November, 1928, to Mr. and Mrs. Babcock (Elsie Smith, Hospital for Sick Children, 1920), a daughter.

**BARNES**—On December 4th, 1928, at Walkerville, Ont., to Mr. and Mrs. A. W. Barnes (Eleanor Davies, Hamilton General Hospital, 1924), a son (Douglas).

**BLIGHT**—October 8th, 1928, at Winnipeg, to Mr. and Mrs. W. J. Blight (Ruth T. Parsons, Waterville), a daughter.

**BRAITHWAITE**—On March 6th, 1928, at Toronto, to Mr. and Mrs. Jas. Braithwaite (Evelyn Hanna, Toronto General Hospital, 1920), a daughter (Ruth Mary).

**BUCKLEY**—On October 13th, 1928, at Montreal, to Mr. and Mrs. E. Buckley (Ida Ibister, Brantford General Hospital, 1924), a daughter.

**CRIDLAND**—Recently at Toronto, to Mr. and Mrs. James Cridland (Lottie Banton, Toronto Western Hospital, 1925), a daughter.

**DRUMMOND**—On November 23rd, 1928, at Los Angeles, to Mr. and Mrs. Harvey Drummond (Margaret Howe, Winnipeg General Hospital, 1911), a daughter.

**FULLERTON**—On November 15th, 1928, to Mr. and Mrs. Burgess Fullerton (Chrissie Higgins, General Public Hospital, Saint John, N.B., 1924), a son.

**HUBLEY**—On November 27th, 1928, at Toronto, to Mr. and Mrs. Kenneth Hubley (Carrie Heney, Grace Hospital, Toronto, 1922), a son (David Eric).

**JACQUES**—On September 23rd, 1928, at St. Catharines, Ont., to Mr. and Mrs. Arthur Jacques (Ethel Dell, St. Catharines General Hospital, 1922), a son.

**MORRISON**—In August, 1928, at St. Mary's, Ontario, to Mr. and Mrs. W. Morrison (Winnifred Allan, Toronto General Hospital, 1922), a daughter (Joan Katherine).

**STEELE**—On November 13th, 1928, at St. Catharines, Ontario, to Mr. and Mrs. Wilfred Steele (Mary Metcalfe, St. Catharines General Hospital, 1923), a son.

**STOREY**—In November, 1928, at Riverside, Ont., to Mr. and Mrs. Storey (Marion Star, Hospital for Sick Children, 1917), a son.

**WILLIAMS**—On November 12th, 1928, at Winnipeg, to Mr. and Mrs. A. Williams (Olive Mitchell, Montreal General Hospital, 1925), a daughter.

### MARRIAGES

**BOARDWAY—ROMBOUGH**—On November 8th, 1928, at Finch, Ontario, Mabel Rombough (Toronto Western Hospital, 1925), to Cecil Boardway, of Toronto.

**BROWN—WEBSTER**—On October 17th, 1928, at Montreal, Ruth Helen Webster (Hamilton General Hospital, 1926), to Alexander Brown, of Montreal.

**COSTER—JONES**—On August 28th, 1928, at Petitecodiac, N.B., Katherine Jones (St. John's Hospital, 1927), to the Rev. Selwyn Coster, of Rothesa.

**DICKESON—WOODSWORTH**—On December 11th, 1928, at Edmonton, Marion Josephine Woodsworth (Royal Alexandra Hospital, Edmonton, 1926), to Donald Charles Dickeson.

**DWYER—QUINLAN**—In July, 1928, Frances Quinlan (St. Joseph's, Hamilton), to Edward Dwyer, of Hamilton, Ont.

**FITZGERALD—KINNEY**—On September 15th, 1928, Cleophas Kinney (St. Joseph's, Hamilton, 1924), to Dr. Gerald Fitzgerald.

**GORMAN—CUNNINGHAM**—On June 8th, 1928, at Arnprior, Anna Cunningham (Hotel Dieu, Kingston, 1917), to John Gorman, of Detroit, Mich.

**HARVEY—BARRY**—On November 14th, 1928, in New York City, Emma Ella Barry (General Public Hospital, Saint John, N.B.), to Herbert Stanley Harvey. At home, 154 East 28th Street, New York City.

**KAJOK—McCANN**—On November 3rd, 1928, in Brooklyn, Lillian McCann (Kingston General Hospital, 1921), to Edward Kajok, of Brooklyn, N.Y.

**KNAPP—REDMOND**—In Detroit, Helen Redmond (Hotel Dieu, Kingston, 1919), to Mr. Knapp. At home—Lansing, Mich.

**MACLEOD—MACLEAN**—On September, 26th, 1928, at North Wiltshire, P.E.I. Florence May MacLean (Royal Victoria Hospital, Montreal, 1928), to the Rev. W. J. MacLeod, M.A., B.D., of New Glasgow, P.E.I.

**MOLKE—JOHNSON**—Recently in New York City, Ethel M. Johnson (Hospital for Incurables, Toronto, 1928), to Herbert Molke.

**SIMPSON—BRAY**—On August 24th, 1928, at Huntsville, Ont., Eva Bray (St. John's Hospital, Toronto, 1927), to Errington Simpson.

**THEAL—FERGUSON**—Recently at Evanston, Ill., Susie Ferguson (St. Joseph's, Hamilton, 1924), to Mr. Theal, of Evanston.

**THOMPSON—BING**—On July 21st, 1928, in Toronto, Margaret Bing (Hospital for Incurables, Toronto, 1925), to Albert Thompson.

**WHITTLES—SMITH**—At Montreal, in July, Miss Winnifred Smith (Montreal General Hospital, 1921), to Thos. Whittles, of North Bay, Ont.

**WILLIAMS—JOHNSTON**—In March, 1928, at Collingwood, Ont., Mabel Johnston (St. John's Hospital Toronto), to the Rev. Mr. Williams.

### DEATHS

**BYRNE**—On July 18th, 1928, at Perth, Ont., Florence Byrne (Hotel Dieu, Kingston, 1920).

**EVANS**—On October 13th, 1928, at Toronto, Avarine Maude Evans, formerly superintendent, Toronto Graduate Nurses' Club.

**FRASER**—On November 18th, 1928, at Hamilton, Ont., Jessie Fraser (Brantford General Hospital, 1920).

**HASTINGS**—On November 25th, 1928, at her home in Quebec City, Mrs. (Dr.) Hastings (nee Gladys Nelson, Montreal General Hospital, 1917).

**LA HIFF**—On October 18th, 1928, at Hamilton, Ont., Margaret La Hiff (St. Joseph's, Hamilton, 1918).

**MACKINNON**—On November 4th, 1928, at Sherbrooke, P.Q., Mary Louise Bowman, wife of George D. MacKinnon.

**McINTOSH**—On October 25th, 1928, Jessie McIntosh (Mack Training School, St. Catharines, 1882).

**STOREY**—On November 21st, 1928, at Saint John, N.B., Georgina Alward Storey (General Public Hospital, Saint John).



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### CONTENTS

### PAGE

THE MENTAL HYGIENE MOVEMENT IN CANADA - - - - -	59
CHILD WELFARE IN NEW ZEALAND - - - - - <i>Olive M. Garrood</i>	62
THE ROYAL NEW ZEALAND SOCIETY FOR THE HEALTH OF WOMEN AND CHILDREN - - - - - <i>Aileen Partridge</i>	64
THE NURSE AND THE LAW - - - - - <i>Harold Fisher</i>	70
THE INTERNATIONAL COUNCIL OF NURSES - - - - -	75
DEPARTMENT OF NURSING EDUCATION:	
THE TRAINING OF A PUBLIC HEALTH NURSE - - - <i>E. Kathleen Russell</i>	78
DEPARTMENT OF PRIVATE DUTY NURSING:	
THE NURSING OF THE MENTALLY SICK - - - <i>Claudia M. Fleming</i>	83
DEPARTMENT OF PUBLIC HEALTH NURSING:	
INDUSTRIAL NURSING - - - - - <i>K. S. Perrin</i>	87
BOOK REVIEWS - - - - -	89
NEWS NOTES - - - - -	92
OFFICIAL DIRECTORY - - - - -	101

# The Mental Hygiene Movement in Canada

At the tenth annual meeting of the Canadian National Committee for Mental Hygiene, Dr. Charles F. Martin, Dean of the Faculty of Medicine, McGill University, and President of the Committee, said in part:

Mental Hygiene is, in reality, nothing new. In its present organized form it is the practical reincarnation of a doctrine preached centuries ago by Plato, when he urged upon physicians to consider the souls of their patients as well as their bodies.

Even today, modern medical science has its limitations and scarcely touches the human mind, nor does it penetrate, as said St. Augustine, into that *abyssus humanae conscientiae* — the abysmal depths of personality. A man comprises something which not even the spirit of man, which is in him knows. "*Esi aliquid hominis.*"

The mental hygiene movement, then, is the offspring of a love for the human kind, a recognition that this is perhaps the greatest medical problem that has yet been approached—the most important and far-reaching, because it tears at the heart-strings of every man, woman and child.

It attempts, through organized effort, to supplement the successes of science, appealing to the human mental factors which contribute so essentially to health and success in life.

Mental disorders enter into the experience of every human being, and it is only a matter of degree whether our disorder be some emotional disturbance, some kink in our personality or a grave psychosis demanding custodial care.

This is the modern view supported by scientists the world over.

Why not, then, learn to face frankly the significance of the term "mental disorder"? Why not realize that the morbid jealousies, the seclusiveness, the emotional upsets and the nervous dyspepsia, are just as much mental disorders as is dementia praecox; for

do they not all arise from the same group of factors, some mild in type and others more severe?

Let us realize the misconception that probably exists in your mind, and often in that of the medical profession, as to the significance of the term insanity. It is high time for us to learn that insanity is merely a legal term, to be adjudged by the courts, not by the physician. Insanity is not something apart, but merely the end product of mental and social failure, of the same group of disorders that induces the tantrum in the child, the anxiety neurosis in the girl, and the many emotional disturbances that affect life in the home.

The causes of these mental disorders are far more numerous than were ever before recognized. Heredity and predisposition are only two of many factors, and are in themselves indifferent as causes: an established fact which should allay the fears of those with unfortunate family histories. These mental disorders are associated as well with a thousand and one physical and physiological factors, even more than with causes psychological. It is for reasons such as these that the nightmares of childhood are just as much in need of serious consideration as a discharging ear or an intestinal disorder. Modern psychiatry has amply justified this fundamental and important truth.

And hence it is that the mental hygiene movement is not to be entrusted to the mercies of the psychologist alone, but has every need of the sound physician of judgment and experience.

This is not a mere psychological problem, but involves the broad principles of medicine and all the physical factors that go to make up general health.

May I tell you confidentially that the ignorance of the average physician as to the factors underlying mental disorders, more especially in children,

is something appalling. But we cannot blame the medical profession for this. Universities and medical schools have never yet been brought to realize how much the responsibility is theirs, nor what a message the mental hygiene movement could convey. Few there are among our practitioners who have been adequately taught to regard the mental care of the growing child as equal in importance with the care of his digestion, or who regard abnormal behaviour manifestations as significant as a chronic appendix. How few physicians there are familiar with the technique of examining the mentality of the growing child! How many concern themselves with the educational programme of the schools, or with the activities of its medical inspectors? And yet herein lies one of the fundamental problems concerned with the child's future happiness and success in life.

Sad, is it not, that to the average scientific physician the patient is but a physical-chemical product, devoid of personality, and seemingly without a world of his own, full of emotions, cravings and repressions?

The rise of specialism, the gradual elimination of the family physician, has but tended to intensify this point of view. The modern patient with some obscure malady is relegated to a syndicate of doctors, each interested in his own narrow sphere, and all too often, when a diagnosis is finally achieved, the personality of the patient receives but the scantest of attention. Is it any wonder, then, that the cults can flourish? But I am digressing. What of this mental hygiene movement? — its aims, its methods, its *raison d'être*. I will tell you briefly, even at the risk of repetition of seeming platitudes.

Its purpose is two-fold. First, the prevention of nervous and mental disorders; and, second, the better care and treatment of those afflicted.

How does it endeavour to achieve results? Primarily by education, by a dissemination of knowledge concerning the facts, and, lastly, by research.

Some of these facts are astounding in their revelations.

There are 24,000 patients in public mental hospitals, and their upkeep is maintained at an annual cost of \$9,000,000.

There are in this country more hospital beds occupied by mental patients than there are patients in all the general hospitals of the land. Add to this the fact that there are as many insane mental patients to-day outside of mental hospitals as there are in them: and when I tell you that communicable diseases are more rapidly spread through their agencies than through any others, you will realize the menace there is to this country.

The captains of great industries are only beginning to notice how large a percentage of accidents and poisonings occur among their feeble-minded employees. The time is at hand when every physician is beginning to learn that disturbances of emotion and personality must be remedied if, in an industry, efficiency is to be increased and stability of labour is to be maintained. Happiness and loyalty follow of themselves, in industry, when mental hygiene principles are pursued. It is not generally known that Canada has at present 60,000 of pronounced mental deficiency, not to mention the tens of thousands suffering from more or less serious nervous disorders which can neither be classified as insane nor as mentally deficient.

A careful, systematic inspection of the schools has revealed the fact that approximately four per cent of all school children (a greater number than graduate from our Canadian universities) are in need of mental hygiene treatment, without which they will inevitably become the victims of grave forms of mental disorder.

What, then, is to become of our national efficiency, when mental defects result in greater national degradation than do all the physical disorders combined?

These are some of the facts revealed by our National Committee, and for which this volunteer organization has been stimulated to activity.

No other organization or corporation is charged with such a task. Upon no group of men or individuals does it



devolve to correct these defects of national importance. True, it is essentially a matter of public health, of medical practice, and of social service—the function of governmental supervision and legislation; but in the absence of organized effort, the Mental Hygiene Committee has bent itself to the voluntary task of aiding in the solution of this as a national health problem. The public health official on whom has been placed the problem of organic and communicable disease, and who is charged with the custodial care of the mentally sick, is at last reaching out for these larger problems of prevention in mental disorders. The mental hygiene point of view has impinged upon his retina and entered his consciousness as never before.

Meanwhile, the National Committee has endeavoured, by means of education, to advance the cause of prevention and cure. You would scarcely credit the extent to which this education has gone in the decade of its achievement.

Let me confess that the educational process began with college presidents, with deans, and professors in medical schools. Next came the psychologist. The psychologist, jealous of his own status, soon realized the limitations of his knowledge and experience in the practical field of mental hygiene, and gladly joined our colours, eager to learn and profit, and ultimately to help. Today the psychologist to whom mental hygiene makes no appeal is as the old man who, unable to keep pace with the rapid current of medical science, creeps up on the bank and silently watches the stream of progress flow by him and beyond. Education came next to the teachers in our schools, to the social workers and the nurses. Soon, too, it became evident that to governments, federal and provincial, might be offered advice, suggestions, and service, to further this national health problem. And lastly, the greatest of all, came the education of the average citizen, for, without public and individual participation, no permanent benefit will ever ensue. A well-defined public

opinion is always the precursor of sound legislation.

And so the scope of our educational programme has been a wide one indeed, and its results have exceeded our most sanguine hopes.

In our medical schools better facilities were rapidly afforded for instructional research. Courses of study were reorganized, amplified and improved. More and better teachers were added to the staffs, mental clinics were established in our general hospitals, while the principle of prevention of mental disorders, as a public health measure, has been increasingly intensified.

Nor has our educational programme ceased with this. Fourteen fellowships were acquired to encourage young university graduates in study abroad in order that they might bring back to our Committee the best that foreign countries had to offer in practice, teaching and research. For the first time in the history of Canadian universities a group of twenty scientific experts in the field of medicine have gathered together, co-operating in closest harmony on these great problems of national importance. Well would it be, indeed, if other departments of science would emulate the example of the Canadian National Committee for Mental Hygiene.

And now, but a word of the influence exerted by this movement on the governments of Canada, of the interest and enthusiasm that was aroused in them by our Medical Director. In seven provinces of the Dominion, surveys made at the request of the governments were followed by consultations which had far-reaching results. Six million dollars have been spent in Canada to raise the standard of hospital, institutional and social practice, and never yet has any government demurred at the cost. Mental hospitals were erected, psychopathic clinics were established, schools for the feeble-minded and institutions for mental defectives were built. If you would have an example of what wise legislation, skilled medical direction and mental hygiene principles can

do, visit the Rockwood Mental Hospital at Kingston, go to the Institution for Mental Defectives at Orillia, and you will realize what can be done in the spirit of humanity and science, not only to make hopeless victims happy, but to restore mental patients to health. And lastly, time does not permit me more than to mention the two hundred classes for mentally deficient children organized throughout the country, the training schools on the farm colony plan, and many kindred activities too numerous to mention.

Great foundations have come to appreciate the importance of this volunteer effort: \$100,000 has been granted for the maintenance of two nursery schools for the study of mental processes in children of the pre-school age. Organized mental hygiene, then, looks to governments, to the doctor, the university, the social worker and the citizen for aid in its great work. Not least among our activities have been the classes on parent education instituted throughout the country, projecting a flood of light on the problems of the home, on the relations of parents to children, on the role in the family life of the educational training of the child. How often does the hand that rocks the cradle unwittingly plant the seeds of permanent mental ill-health! The parent is taught his duty in the supervision of the child—his idiosyncrasies and behaviour, his daily

hygiene of sleep and food and play, his vocational adjustments and his emotional conflicts.

You will admit, then, that this mental hygiene movement is a healthy, if precocious child, and for one of his years must have an intelligence quotient of at least two hundred. Never has there been so bright a future; never has there been so much encouragement; but never has there been so much need for an intelligent understanding on the part of our average citizen. The public must learn more and more that this is a national aim, and just as the obliteration of tuberculosis, malaria and yellow fever was achieved when they became national conceptions, so the same thing is in the field of mental disorders. More experts are required in the field, and the public must be taught to accept leadership as a duty to society and the state. Mental hygiene must inevitably make its appeal to you and to me, to everyone who enjoys the privilege of a home and who appreciates the full significance of useful citizenship.

The problems of mental hygiene cannot be solved by science alone. Much, indeed, could be learned of this great movement by a careful searching of the Scriptures or by a study of the saints, or, best of all, perhaps, by following the doctrines and practice of St. Francis of Assisi, the greatest human experimentalist of them all.

---

## *Child Welfare in New Zealand*

By OLIVE M. GARROOD, School Nurse, Kamloops, B.C.

The following article was written by Miss A. Partridge, honorary secretary of the Plunket Society branch of Auckland, New Zealand. She has been an ardent and faithful worker for many years. When I was asked to write something for *The Canadian Nurse*, I thought many of its readers would be interested in this brief history of Sir Truby King's work as an introduction.

When I was in charge of two dis-

tricts for four and one-half years, following my training in Dunedin, New Zealand, I was more than convinced of the value of his work.

The fundamental principle of the great success of this system is breast-feeding. The great importance of this cannot be overlooked. Many hundreds of mothers have been helped to feed their babies in the natural way. Regular three or four-hourly feeding is most essential. No night

feeding between 10 p.m. and 6 a.m. gives both mother and babe rest which is most necessary.

A very important feature is the stripping of the breasts after each feeding. Test feedings are given to ascertain the exact amount of milk the baby is getting from the mother. This is done simply by weighing the baby with clothes on before and after feeding. When the baby does not get the required amount the shortage is supplemented with humanized milk immediately after each feeding.

A twenty-four hour specimen of the mother's milk is usually taken and tested by the Plunket nurse in charge to find the percentage of fat. Many mothers have a high percentage of fat, due to the fact that they overfeed themselves with milk and cream. The babies then naturally suffer from indigestion. Young babies cannot assimilate a high fat percentage.

Then the mother is taught how to re-establish her milk supply. Breast milk has been completely restored even after a baby has been weaned for three weeks. The following is the routine treatment for re-establishing the milk supply. The method is very simple.

Take two basins, one of hot and one of cold water. Bathe first one breast alternately with the hot and cold water for about ten minutes, then the other breast in the same way. Always start with hot and finish with cold. Then rub vigorously with a towel and massage the breasts. The treatment should occupy from fifteen to twenty minutes. This treatment should be given twice a day. The mother should have a simply-balanced diet: that is plenty of fresh fruit, whole wheat bread, etc., and not too much milk. The old idea of eating for two has been quite abolished. A glass of water always should be taken by the mother immediately before nursing her baby. I have never known this method of Sir Truby King's to fail when carried out systematically.

The mother should rest every afternoon and take regular walking exercises daily. "The Expectant Mother and Baby's First Month" by Sir Truby King is a splendid book written along these lines. When mothers are really anxious to feed their babies as Nature meant them to be fed, they will persevere until they are successful.

*It can be done.* The sooner that mothers, who are the architects of humanity, realize their grave responsibilities to our future generation, the sooner we shall build a healthier, happier nation. It is amazing to see the large number of babies who are weaned at an early age. For the slightest excuse they are put on to cow's milk and water. In these mixtures there are very high percentages of protein, in many cases from 2 to 3.5%. I am sure Nature intended human babies to have the percentage as provided in the mother's milk.

Note the following tested comparisons:

	Sugar	Fat	Protein
Mother's Milk .....	7	3.5	1.5
Humanized Milk .....	6.9	3.5	1.5
Cow's Milk .....	5	3.5	3.5
Unbalanced mixture			
—Cow's milk with			
water and sugar			
added .....	8.6	2.0	3.0

Many babies are given whole milk at the age of seven or eight months with a protein percentage of 3.5. Sir Truby King has reduced the infant mortality in New Zealand to the lowest in the world by realizing the great importance of breast-feeding and balanced percentage feeding for babies needing artificial food. These mixtures are worked out scientifically to exactly the same percentage as the human milk. That is why it is called humanized milk. He has devoted twenty years of his life to this great study for humanity's sake. Surely he should be recognized as a great benefactor to mankind. It is surprising to find that in spite of this re-

search work done by him that one still finds people who criticise and do not believe in his methods. Yet he has saved thousands and thousands of lives. His motto has always been, "It is wiser to erect a fence at the top of a precipice than to maintain an ambulance below."

Note the following recent statistics. They speak for themselves:

**Deaths From Infant Diarrhoea (Enteritis)**  
Under 2 years, per 1,000 births.

New Zealand .....	2.25
*Dunedin (Home of Plunket System) .....	.8
Australia .....	18.
Great Britain .....	15.
Canada .....	24.
Vancouver .....	3.5
United States .....	15.

\*No deaths in last 2 years.

New Zealand .....	1907	9.
New Zealand .....	1926	2.5

**Infant Mortality, Under 1 Year,**  
**Per 1,000 Births**

New Zealand .....	38.71
Canada .....	78.
British Columbia .....	58.4
Vancouver .....	44.
United States .....	77.
Great Britain .....	75.
Australia .....	57.

New Zealand .....	1907	88.8
New Zealand .....	1927	38.74

One can only make the deduction that the high percentage of loss of life is due to wrong feeding. Truly, "The being of a baby is a risky problem" (Dr. Carden). How many of us realize that our strength as a nation depends on our moulding and building of these children who are our future generation? Surely we need healthy, happy citizens to carry on the progress of Canada and the advancement of our British Empire.

## *The Royal New Zealand Society for the Health of Women and Children---A Brief Account of its History*

By AILEEN PARTRIDGE, Auckland, New Zealand.

### I

In writing this brief account of the foundation of the Plunket Society it is necessary first of all to give some idea of the master mind directly responsible for its origin.

Frederick Truby King was born at Taranaki over seventy years ago (1858). At the age of 22 he left New Zealand to commence study at the University of Edinburgh. After a very brilliant career at the Medical School there, during which time he won that much coveted honour, The Ettles Scholarship, he spent some years in further study in Scotland and England. Then he spent considerable time in studying public health, and was one of the first few graduates in the then new subject of preventive medicine. He specialized in mental diseases, and some years later he returned to New Zealand and after holding several important posts he was in 1889 appointed Medical

Superintendent of the Seacliffe Mental Hospital which is situated some twenty miles from Dunedin. He was also appointed lecturer in mental diseases and examiner in public health at the Otago University. In 1894 he returned to England to study brain pathology and nervous and mental diseases, qualifying as a member of the Psychological Association.

At Seacliffe Mental Hospital there were five hundred patients committed to his care, and he had entire charge of the large farming estate attached. He had no previous knowledge of farming, yet, in a remarkably short time he had mastered the whole subject from the growing of crops to the rearing of stock, with the result that within a few years Seacliffe carried off all prizes at the large agricultural and pastoral shows held at Dunedin, until the farmers of the surrounding districts entered a protest at govern-



ment institutions competing. Dr. King gave the closest attention to the simple and natural requirements of his stock, such as fresh air, correct feeding, etc. Coddling of calves was done away with, they were taken out of stuffy sheds and put under paling verandahs open to the sun all day though sheltered from the cold winds at night. Fed systematically in this way, I am told that these calves gained on an average over 100 pounds more in their first six months than they had gained previously, and more important still, none died, though previously many had succumbed to "scouring," or, as we say of babies, "infantile diarrhoea." I understand that the system arranged then by Sir Truby King has never been changed.

Next the poultry came in for their share of attention. Special treatment was given them with the same results. Fowls at three months were sent to Dunedin markets weighing four and a half pounds, and the supply of eggs went up by leaps and bounds until it rose to nearly a hundred dozen a day in spring, and I understand the return from the poultry farm alone was some £12,000 a year.

The potato crop yielded equally remarkable results on the application of scientific knowledge of requirements and proper system.

All this time Dr. King was carefully studying the welfare of the patients confided to his care. The grounds of the hospital were beautifully laid out and improved, sunk fences were arranged so that there were no "shut in" appearances, and the full benefit of the glorious view stretching far out to sea and along the coast line could be enjoyed. A separate cottage for convalescent women was built and tastefully furnished and carefully designed under Dr. King's personal supervision.

The application of these fundamental health principles conduced greatly to the improvement in the

general health of the patients. Dr. King's intimate knowledge of every patient was remarked upon by the Inspector General of Hospitals in one of his annual reports.

I have wanted to make it clear that before Dr. King went into the question of the feeding and care of the baby he had conclusively proved that Nature's law as applied to plants and animals equally obtained with regard to the human race though up till this time practically no attention had been directed to the fact.

Always a profound thinker, Dr. King was deeply stirred at the amount of suffering that came before him. Much of it he felt sure was preventable and he set about finding some solution of the problem. It was his conviction that the terrible increase in mental diseases could only be stemmed by beginning at bed-rock, that is, teaching women how best to care for themselves and their children. Dr. King was a keen student of social economy, and when investigating the statistics of the time he was appalled to find that in this new young country with its temperate climate and good conditions generally, the infant death rate was almost 90 per cent. This was the deciding factor. He felt convinced that this blot on our country's name could be wiped out if mothers, both prospective and actual, were roused to some system of education in mothercraft, and he commenced to give all his indomitable energy to the cause of mother and child. He had nothing to work on but his previous experience with plants and animals, for until this time no practical work of the kind had ever been attempted, although as far back as the middle of the last century both Herbert Spencer and Florence Nightingale had pleaded that some such education be given to the young womanhood of the nation, so that, in the words of Florence Nightingale, "They might hand the lamp of life more worthily on."

Dr. King and his devoted wife began by working quietly amongst the mothers and babies in and around the village of Seacliffe. For about three years they battled on alone. In common with all men who set out to blaze a trail through the jungle of ignorance and have the courage to preach doctrines in advance of the time, Dr. King had an uphill fight against the forces of apathy, ridicule and ignorant prejudice and was made to suffer martyrdom at the hands of the whole tribe of dullness and mediocrity. In these early days there was little or no supervision of licensed homes, and some glaring cases of "baby farming" came under Dr. King's notice. On one occasion he found three terribly emaciated little babies in a stable adjoining a house. They were stone cold and in a dying condition. There was no place to send them so Dr. King and his wife opened their own seaside cottage on the Karitane Peninsular, four miles from Seacliffe, and here, under Dr. King's guidance, his wife, with the aid of a young Scotch girl, nursed these poor wee waifs back to robust health. In all, thirteen of these babies were treated in this improvised baby hospital, and although all were in a dying condition when admitted, not one died. Good homes were found for them, and they were given a chance that did not seem possible at the beginning of their poor little lives.

As a result of this initial success in a small way Dr. King's self-imposed task came under the notice of some public hearted citizens and in 1907 a public meeting was held in the Town Hall, Dunedin, which resulted in the formation of the Plunket Society. For a time only the few and far-seeing gave active support. The majority held to the theory that what was good enough for their grandmothers was good enough for them, forgetting that civilization was undermining humanity everywhere, and creating new problems that could only be dealt with by more modern

methods. About this time also the late Mr. Woolfe Harris gave to this new society his cottage and large grounds at Anderson's Bay, Dunedin, and the babies were transferred there from Dr. King's own home which had become known as the "Little Karitane Baby Hospital." This small beginning has become the training centre for Plunket Nurses for the whole Dominion.

Progress at first was slow, but one by one the cities and towns recognized the benefits of the society and requests came from all parts to have branches set up.

Dr. King's work at Seacliffe prevented him from leaving Dunedin for any length of time, and knowing full well that success depended entirely upon the tact and understanding of those to whom the organizing of these new branches was entrusted he decided to seek the help of the wife of the governor of the time, Lady Plunket. Lady Plunket was the mother of eight young children, and Dr. King's scheme for assisting the mothers of New Zealand appealed to her very strongly. As she travelled from centre to centre she called meetings of interested citizens and set up representative committees. These made themselves responsible for financing the branches and for the general administration of them. In honour of Lady Plunket the nurses who were appointed to work, under Dr. King's guidance, at the various branches, were named Plunket Nurses—the name by which they are still known. By 1912 when the society had been in existence some five years statistics showed such a big drop in the infant mortality that Dr. King was set free from his post at Seacliffe for three months and asked by the government to establish branches wherever he could find women willing to undertake the management of them. By 1917 the society's work had created great interest abroad and towards the middle of that year the authorities in Eng-

land, appalled at the terrible wastage of infant life there, cabled to Dr. King to go over and establish his New Zealand system at the heart of the Empire.

To establish a new hospital in London during war time was no light task, as the work was hampered by every kind of restriction.

Miss Pattrick (now the Director of Plunket Nursing) was on war service at this time and the military authorities released her so that she might assist Dr. King in his new crusade.

Between them they overcame incredible difficulties and the Karitane Hospital and Mothercraft Training Centre founded by them in 1918 has been successful beyond their wildest hopes. Since then many Plunket Centres have been established, in South Africa, Palestine and many of the Australian States.

Immediately after the war Dr. King was appointed one of three British representatives of child welfare interests at an inter-allied Red Cross conference which sat for nearly a month at Cannes, Riviera. He was then appointed by the War Victims Relief Committee to visit Austria and Poland in the interests of women and children.

Soon after Dr. King returned to New Zealand, in 1921, the government appointed him Director of Child Welfare, and in this capacity he acts with the Department of Health in conjunction with the Plunket Society of which he is still the general president and supervising genius: guiding, leading, fostering weak branches, investigating every scientific point, and carrying on at the same time an enormous correspondence with the outside world.

In January, 1925, Dr. King's services were recognized by his having the honour of Knighthood conferred upon him.

## II

One is constantly asked "What is the New Zealand System of Child Welfare?" Wherein does it differ from that of other countries.

Speaking before a medical club in London some years ago Professor Kenwood deplored the fact that practically all London's many infant centres were giving out widely conflicting and utterly irreconcilable advice; he said what seemed to him most necessary for the betterment of the race was the dissemination of uniform, authoritative advice on the rearing of infants. This ideal has been more nearly achieved in New Zealand than anywhere else in the world with results that have been universally recognized and appreciated. *Diversity of opinion on matters of detail will always obtain in all spheres of practice*, but Sir Truby King has succeeded in placing New Zealand on the one broad system that has met with general approval and won the intelligence of the country.

There are still those amongst us to whom the Plunket System means nothing more than a baby and a bottle of humanized milk.

It is something rather more than this.

At its head is Sir Truby King, Director of Child Welfare under the Department of Health, Wellington.

Next is Miss Pattrick, Director of Plunket Nursing, whose headquarters are at the chief training centre—Dunedin, and who visits all the main centres at least twice annually, and the smaller centres once annually to confer with the committees and Plunket Nurses; also she examines the trainees at all the Karitane Hospitals in their practical work. In this way the whole work is co-ordinated and uniformity is maintained.

The society maintains a band of 130 District Plunket Nurses (the great majority of these being nurses with wide experience in all branches of nursing and chosen for their general suitability for welfare work).

At all the main centres it has its Pre-natal Clinics, its Infant Welfare Centres and its Karitane Hospitals and Mothercraft Training Centres.

#### *Pre-natal Clinics*

To the Pre-natal Clinics patients come once a month (or more often if the patient or her doctor wishes it). During the last two months of pregnancy she is urged to attend once a fortnight.

Advice is entirely free of charge. The nurse in charge sends monthly reports to the medical officer of the district. Patients are urged to visit their *own* doctor, the latter is at regular intervals kept informed of his patient's general condition.

The clinic nurses also carry out *external* pelvimetry, urine testing, recording of blood pressure, and advice is given on such points as general hygiene, the correct preparation and cooking of suitable diet, clothing essentials and preparation of baby's outfit.

The making of suitable maternity supports, also labour outfits—(expectant mothers may have standard maternity outfits packed and sterilized free of charge).

In addition to verbal advice booklets are issued to patients free of charge.

The nurses in charge do *not* advise treatment of any kind. Suspected abnormalities are immediately referred to the patient's *own* doctor.

Busy physicians are finding these clinics a great boon, and are advising their patients to attend regularly.

#### *Post-natal Work*

The society maintains Infant Welfare Centres in all the principal towns in the Dominion. From these centres the District Plunket Nurses visit the homes in the surrounding country. Mothers of all classes are encouraged to bring their babies to the centres for regular weighing and supervision.

To ensure that all mothers may know that the help of the nurses is available to them, the nurse in charge

of each centre is supplied by the local registrar with a daily list of births registered. These lists are treated with strict confidence. A few weeks later a tactfully worded letter is sent to each mother offering her the help of the nurse's services. A printed slip is enclosed which the mother is asked to return to the nurse if she wishes her to call. The Plunket Nurses do not go into any home uninvited. The mothers are instructed in the management of natural feeding and general mothercraft.

The main function of the society's nurses is to educate and help parents and others in a practical way in the hygiene of the home and nursery. The society knows no class distinction. To the Plunket Nurse a baby is a baby whether cradled in a mansion or a cottage. At the Plunket Centres all meet together on grounds of common motherhood and humanity without any trace or suggestion of patronage or charity.

At all Plunket Centres detailed records of all cases are kept, and in the event of a mother moving from one town to another her records are sent on to the nurse at the second centre where the mother will attend so that the new nurse may take up the case exactly where the first left it, and so carry right on without any unnecessary experimenting or upset to the baby.

#### *Karitane Hospitals and Mothercraft Homes*

In one sense the healing of sick babies is the least important aspect of the society's hospitals—the institution is a school for mothers—an ever open object lesson by means of which hundreds of visitors of all classes see and are taught personally every year the essentials for healthy motherhood and babyhood. At the cottages for mothers which are usually attached to the Karitane Hospitals conditions are made to conform as far as possible to those in an ordinary home, and too much hospital routine is avoided.



The cottages are simply but attractively furnished and are surrounded by pretty gardens. Nursing mothers who are experiencing difficulty in rearing their babies are encouraged to become inmates for a week or longer so that they may be set on the right track.

At the main hospital skilled treatment is available for babies who have passed beyond the simple treatment that can be carried out in their own homes.

The Karitane-Harris Hospital, Dunedin, is used by the university as the institution for the practical and clinical teaching of pediatrics to our medical students and by the professor of domestic science for teaching the students this aspect of their work.

#### *Propaganda*

In addition to these institutions and welfare centres, the society carries out widespread propaganda by means of press articles. In all, some fifty newspapers throughout the Dominion publish "Our Babies" column, weekly, free of charge. In this way practically all the mothers in the Dominion are kept in touch with the work of the society. During last year 75 per cent. of all babies born in the Dominion came under the care of the Plunket Nurses. A constant stream of correspondence from every part of the world pours in and Sir Truby King's text books have been translated into seventeen different languages.

#### *Fellowship for Research Work in Child Welfare*

The latest forward move made by the society has been the founding and endowing of a University Fellowship for Research Work in Child Welfare attached to the Dunedin Medical School, and it is felt that such a fellowship will tend to cause a great deal more time and thought to be given to the paramount importance of the subject of Child Welfare, and it is hoped that it will attract the serious attention of some of the more able and ambitious students at the medical school.

The fellowship is called "The Lady Truby King Fellowship" in honour of the late Lady King who for twenty years rendered such splendid service to this country, and who shared equally with her famous husband in all his humanitarian activities.

#### *In Conclusion*

It will be seen from a small beginning that the Plunket Society has become one of the biggest and most powerful organizations in the country.

Today it has its branches in some five hundred centres in New Zealand, and has spread to many other parts of the world.

In conclusion it is well to emphasize the fact that the society's work is mainly preventive; its policy has always been to go to first causes. In the words of Sir Truby King, "Social sanity lies in prevention, not in allowing people to drift without rudder or anchor and then trying to drag them off the rocks and re-fit them at ruinous cost."

The Plunket Society is striving not merely to lower the infant death rate but to raise the standard of health generally.

"For the sake of the Women and Children; for the advancement of the Dominion; and for the honour of the Empire."

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#### INFORMATION FOR NURSES IN OTHER COUNTRIES

The Committee on Arrangements for the sixth general meeting of the International Council of Nurses wishes to announce through these columns that the committee will greatly appreciate hearing at an early date from nurses in other countries who are planning to attend the Council. Many offers of hospitality are being received from the citizens of Montreal for the entertainment of visiting foreign nurses. In view of these invitations on file, the committee is making the above request in order that visiting nurses may be provided with the best Montreal has to offer.

## *The Nurse and the Law*

By HAROLD FISHER, K.C., Ottawa.

I have given some thought as to what law a nurse ought to know. I have almost come to the conclusion that there is none. The reason is not hard to find. When I was a youngster, I used to look on the policeman as an enemy. It was not until I was quite a big fellow that I came to realize that the policeman was a friend—a person whose business it was to protect me and mine—and that he was my policeman. There seems to be tendency to look at law in the way I as a boy looked at the policeman. Some people seem to think that the law is a kind of monster of which one should be terribly afraid. That surely is a wrong attitude. The law is really a friendly thing. Laws are merely the rules of the game that exist for the purpose of enabling us to get the most out of the game.

We have a law that says that no one shall drive a car more than twenty miles an hour in the city. Sometimes we feel that this is an irritating restriction. Really this law is made to prevent motorists from killing each other or running down pedestrians. It is our law made for our protection. It is the same with most other laws. For the most part they are reasonable rules such as any sensible person having regard for other people would work out for his own guidance. That being the case, I could cut this lecture short by concluding with the injunction—"Do what your conscience and your common sense tell you is right, and you are never likely to find yourself in trouble with the law."

What a fine thing it would be if the idea which I have expressed were generally accepted—that the law, like the policeman, is our law—not made by some tyrant, but by our-

selves or others who represent us, and made for our protection. It follows from this idea that the man or woman who breaks the law is not playing fair. He is not observing the rules that were set up by him and for him. The good citizen observes the law. Sometimes he may think that in places the law is bad. If he does, he will try to have it changed, but so long as it remains, he will obey it.

### *The Witness*

I expect that most of you will never be in court. Some of you will go there as witnesses. Perhaps it is not a thing to be desired to be called upon to give evidence in court, but at the same time it is nothing to worry about. All that you are called upon to do is to go and tell your story.

When I speak about telling your story, I do not think there is much need to say anything about how it should be told. If I had before me an audience of doctors, there are a good many things I could tell them. One of them would be that when you wish to convey information, it is a good thing to do it in language that the person whom you are addressing will understand. In giving evidence in a court, the language should be such as an ordinary judge or a more ordinary jury will understand.

Sometimes persons who are called to give evidence greatly fear the cross-examination. My experience has been that the person who is in court to tell the truth and the whole truth seldom suffers very much from cross-examination. If you are telling the truth, some lawyer may shout at you or try to put you in the wrong, but in the end, as a rule, he will do himself more harm than he will you.

### *Criminal Law*

Of all law, that of which you need know least is the criminal law. Ignor-

ance is said to be no excuse. Yet most people are ignorant of the law, and get into no serious trouble. The reason, I have suggested—the law is founded on justice and right, and we have sufficient knowledge of what is right to avoid breaking the law. There is only one warning that I might usefully give you, and that is this: No one can authorize you to do wrong or to break the law. I have known cases where nurses have got into nasty jams because they have done what they were told. No doctor's order will justify you in doing wrong, or protect you if you do. One who assists in wrongdoing, even in a minor capacity, is guilty in the eyes of the law. I have known cases where nurses have escaped because others have been more guilty, and nobody has bothered about the nurse. But they have not always escaped. Sometimes they have been made the scapegoat. If you are asked to assist in anything that has the suspicion of being wrong, it is the part of discretion and also of courage to say "No" and to say "No" very resolutely.

### *Wills*

I have asked several people what branch of the law you might be interested in. They have all commenced by saying, "Tell them something about wills." I shall try to tell you a little about wills.

Everyone who has anything to leave behind or is likely to have anything to leave behind, should make a will. In the absence of a will, property of a dead person is distributed according to general rules of law. These general rules frequently result in a distribution which is not best, or at any rate, is not what the deceased person would have wished. Anyone can control the distribution of his property after his death by making a will. Further, even if the property goes by general law where the deceased person would have liked, the absence of a will makes trouble. The

executor of a will needs no bondsmen. To administer an estate where there has been no will, bonds must be got from friends or companies for the faithful administration of the estate. This means trouble and expense.

The time to make a will is when in good health. Sick people are seldom normal. Frequently the perspective is thrown out. Sometimes a relative who is in attendance for the time being is the only person in the world. Others who have served all their lives are overlooked. Sometimes the reverse is the case, and the relative who is working her head off to help the sick person is looked upon as a kind of nuisance, and valued very lightly as compared with the dear one at a distance who simply sends flowers. Sick people may be so abnormal as to be incapable of making a will. Every lawyer has had experiences where he has had doubts as to whether a will should be made or not.

If a will is to be made, it is a good thing to let a lawyer do it, if one is available. We lawyers can make enough mistakes. There is a saying that lawyers live on those who make their own wills. In making a will, all that is necessary is for the testator to say what he wants to say, but as Harry Lauder would remark, "That takes a bit of doing." Lawyers have had more experience than the person who makes no will other than his own.

When a will is drawn, it is desirable not only to dispose of the property but to name one or more executors.

A will must be signed by the testator and must be witnessed by two persons. The most important thing to remember in connection with a will is this—that the person making a will and the two witnesses must all sign, and they must all sign at the same time. A cross made for a signature is quite as effective as the written name. The only difficulty arises from the necessity of proving

that the cross was intended for a signature.

Anyone may witness a will, but there are certain persons who should not act as witnesses. These are the persons who under the will take some benefit. If a person named in a will to receive something acts as a witness, the will is good as to everything except the legacy to that person. This will be lost. The same thing applies where the husband or the wife of a person named in the will acts as a witness. Anyone who hopes to get anything under a will should not act as a witness, and should see that his wife or her husband does not act as a witness.

I always give this advice to my clients: "Make your will as if you were going to die tomorrow—but don't die. When conditions change, make a new will." There should be a general stock-taking of wills at least every five years. Any will can be revoked at any time by another will, and should be changed as circumstances change.

#### *Notes*

One lady whom I asked what to talk to you about suggested that I tell you about promissory notes. I suspect that she has had some sad experience. The only law about notes that you need to know is that if you sign your name on one, either on the front or the back, you are liable to pay it. I would not advise you never to endorse a note, although that might be good advice. I will say this: never sign a note unless you are prepared to pay it.

#### *Deferred Payments*

I have also been urged to say something about the modern system of buying on the instalment plan. Nowadays you can buy almost anything on the deferred payment plan—a motor car, books, a fur coat. All I can say is, do this if you wish, but first read what you sign when you get anything in this way. You will gen-

erally find two things. First, that you have agreed to pay. You cannot get rid of this by sending the thing back. You will be made to pay if there is a way of doing so. Second, you have agreed usually that the thing is to belong to the merchant who sells it until it is paid for in full. A good many people are riding or walking around in things that belong to someone else. If they cannot pay for them someone else may come and take the thing from under them or off them.

#### *Contract of Service*

Your professional employment is governed by the law of contract. When you enter a training school you contract or agree to render services such as may reasonably be expected from an intelligent young woman with no previous training, and the school authorities agree in exchange to teach you.

After you graduate and go to work you will enter into a contract or series of contracts. You will agree, to render services. Others will agree to pay you for these services.

First as to others—I think the most important thing for you to remember is that it takes two to make a bargain. You should always try to make sure that there is some other party to the contract, and that that other party is someone who can pay. If your patient is able to pay, as a general rule you need not have much worry because a contract will be implied even when not expressly made. But if you have to look to someone else for payment, it is always well, tactfully and discreetly, to see that you have a definite agreement about your engagement. For example, you are called upon to nurse an old lady who is living with her son, and who is likely to die. If she dies the son will not be liable unless in some way he has agreed to pay you for your services. It will not be very satisfactory to send in a bill to the old lady's estate if she has no estate.



To make an expressed bargain about your services is not always easy, and sometimes you must take a chance, but the necessity for a contract is something that you should always have in your mind. Work for nothing if you will and must, but where people can afford to pay, do not let them take advantage of you.

Your employers are bound to pay what they agree to pay, or if there is no expressed amount agreed upon, then what is fair and reasonable. The tariff for nursing services is pretty well established. Nevertheless it is often good business to have an expressed understanding as to what your fee will be.

#### *Services Rendered*

In return for your pay you will render services. So far as the law is concerned, a graduate nurse will be bound to render such services as may be expected from a capable and trained nurse. If you fail in this, you will commit a breach of contract, and not have the right to collect your fees. You may even make yourself liable to pay damages.

About the minimum the law requires from a nurse I can say very little. The law says you must always exercise reasonable care. In some cases the courts have held that there was an absence of reasonable care where sponges, hypodermic needles, drainage tubes, bits of dressing or other similar articles have been allowed to remain in parts of the human anatomy where they should not have been left. It has also been decided that there was negligence where human tissue has been destroyed by hot water bottles that have been too hot or have been misplaced. The administration of oxalic acid instead of epsom salts has not been looked upon with judicial favour. In fact, sometimes where there has been carelessness, someone has been ordered to pay large sums of money by way of damages. Usually the hospitals or the surgeons have

been those who have been pursued. Seldom have nurses been sued, but that has been largely because nurses in the past were not financially so strong as they are now, and were not worth suing. But there is no reason why a careless nurse may not be sued. The fact that some institution or some surgeon may be liable for her negligence will not excuse the nurse. She is liable for the results of her own negligence.

The law demands reasonable efficiency and reasonable care. But as I have said the minimum required by the law will not trouble you. The nurse who does not give more than the minimum required by the law would not be a worthy graduate of any hospital. I wish I could suggest the maximum this hospital requires of you. The law demands technical skill. The Civic Hospital demands much more. I do not know whether or not you have read the Life of Sir William Osler. If not you will read it sometime and will learn much. He was asked what particular virtues were needed by a nurse. He said they were seven—"the mystic seven—tact, tidiness, taciturnity, sympathy, gentleness, cheerfulness, all linked together with charity." I suppose anyone who possessed all these virtues would not only be a perfect nurse but a perfect woman.

My observation of nurses would lead me to emphasize some of the virtues named by Dr. Osler, particularly cheerfulness. Of Dr. Osler himself someone once said that his treatment in his medical wards consisted of hope and *nux vomica*. I have seen nurses who entered a sick room as though they were the advance agents of the undertaker. I have seen others who brought with them such an atmosphere of hope and confidence that the patient felt better the moment they entered the room.

Osler speaks of taciturnity. That means the ability to hold your tongue. I could tell you much of slander and

libel, which are the legal terms for indiscreet and reckless talk and writing, but there is no need to use legal terms. All is said when you are told to learn to keep your mouth shut. If you do that, you will not only avoid legal difficulties, but much other troubles.

I have heard it said that the besetting sin of nurses is gossip. I do not know whether this is true or not. If it be true, I think I know why. It is because many nurses have nothing else to talk about but their professional experiences. It used to be said that of the educated classes, the doctors had the least general education and the least culture. In the old days, they studied medicine intensively and exclusively for three or four years, and when they graduated they knew nothing but medicine. That has been changed as to doctors. I am afraid the education of nurses is still very narrow. In your work you get an education that is much more far-reaching than you realize, much beyond mere nursing: "to keep your head when all about you are losing theirs in blaming you," self-possession, poise, something very valuable. But you are given little help with literature and some of the other things which make life finer and larger. Some day this may be remedied. In the meantime, help yourselves in whatever little way you can. I realize that you have little leisure and when you have leisure you are often very tired, but try to have a good book under way, even if you read slowly. Try to keep in touch with what is going on in the world. Remember, when you go into a home, those in that home will expect not merely a person with a certain technical skill demanded by the law, but a lady of culture whom it will be a real pleasure to have in the house.

Now I fear I have not told you much of the law, but perhaps I have at least brought assurance that if you

are good nurses and good women, and strive always to do what is right and noble, you will have no need to fear the law, or even to know much about it.

**Note**—This address was given before the pupil nurses of the School of Nursing of the Ottawa Civic Hospital by Mr. Fisher, three weeks before his death, of pneumonia, in December.

In the passing of Mr. Fisher the nurses of the Ottawa Civic Hospital have lost a good friend. It was very largely due to his efforts, while Mayor of the City of Ottawa, that construction of the Civic Hospital was undertaken, and since its opening in 1924, as a trustee of the institution, he has ever shown himself sympathetic with, and understanding of, the needs and problems of the nurses.

Mr. Fisher was known and loved by the community at large. The whole city mourns his untimely going. But it may be safely said that to no group of the community is the sense of loss more poignant than that at the Civic Hospital, among those who worked closely with him and appreciated something of his hopes and aspirations for the institution which remains his true memorial.

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### *Nurses' Circulating Library*

When the Massachusetts-Halifax Health Commission ceased to function, its library was donated to Dalhousie University. This material has since been available to local nurses in a comfortable reading room at the Dalhousie Public Health Clinic. Arrangements have been made this autumn by the Registered Nurses' Association of Nova Scotia to lend this library material to its members in the province, and the lending rules with a list of the available books is to be sent to these nurses each year.

The financing of the circulation of this library and the purchase of books annually are to be undertaken by the Registered Nurses' Association of Nova Scotia, and Dalhousie University has very generously given the services of a member of their clinic staff for librarian service for a two-hour period each week.

Many nurses have already expressed a keen desire to make use of this library, and we are convinced that this much desired if belated opportunity will be greatly appreciated.

## *Notes on the International Council of Nurses*

### I

There are at present in existence more than 400 international organizations, more than sixty having their headquarters in Geneva. (In the latest Handbook of International Organizations published by the League of Nations in 1927 the number is given as 399.) These organizations are grouped under agriculture, trade and industry; communications and transport; labour; medicine and hygiene; economics and finance; law and administration; arts and sciences; humanitarianism, religion, morals and education; sport and travel; feminism; international languages; bibliography and documentation; disarmament; miscellaneous.

The International Council of Nurses is the oldest of all international associations for professional workers, having been founded in 1899. Examples of other international organizations and the dates of their foundation are as follows: International Dental Federation, 1900; International Society of Surgeons, 1902; International Association of School Doctors, 1910; International Pharmaceutical Federation, 1912; International Association of Midwives, 1925; International Professional Medical Association, 1926.

Among the professional associations for women, the International Council of Nurses is by far the largest in the world, having a membership of 132,000 (among whom are included only some hundreds of male nurses).

An idea of how completely the work of the International Council of Nurses covers the world may be obtained from the following information:—

a. There are 19 affiliated national associations:

The American Nurses Association	70,000
The National Council of Nurses of Great Britain .....	30,000
The Canadian Nurses Association	10,000
The Danish Council of Nurses.....	7,300
The Nurses' Association of Germany .....	3,550
The Norwegian Nurses' Association .....	1,700
The New Zealand Trained Nurses' Association .....	1,600
The Nurses' Association of China	1,400
The National Association of Trained Nurses of France .....	1,100
The South African Trained Nurses' Association .....	900
The National Federation of Belgian Nurses .....	900
The Nurses' Association of Finland .....	850
Nosokomos, Holland .....	700
The Trained Nurses' Association of India .....	500
The National Association of Nurses of Cuba .....	500
The National Council of Polish Professional Nurses .....	450
The National Council of Trained Nurses of the Irish Free State..	400
The Bulgarian Nurses' Association	100
Total .....	131,950
(Italian Association reorganizing.)	

b. There are 11 countries in which the Council has Associate National Representatives, i.e.: Czechoslovakia, Esthonia, Greece, Iceland, Japan, Jugoslavia, Korea, Latvia, Sweden, Switzerland, Turkey.

c. The International Council of Nurses has correspondence with nurses, organizations and governments in 28 additional countries. (Total 58 countries.)

### II

In 1893 when Mrs. Bedford Fenwick, as delegate from the Royal British Nurses' Association (founded in 1887), attended the Congress of Representative Women in Chicago she was entrusted by the Founder of the International Council of Women with the carrying of an invitation to British women to take part in the Council's organization.

When the International Council of Women met in London in 1899, a group of British nurses, stimulated by Mrs. Fenwick and other leaders, requested space in the programme for a nursing sub-section. Following the meeting of this sub-section, at which a number of foreign nurses representing ten nations were present, it was proposed that an International Council of Nurses be organized. This proposal was accepted unanimously, and the Constitution adopted in 1900. Mrs. Fenwick was president of the Council from 1899-1904; Miss Lavinia L. Dock (U.S.A.) acted as secretary from 1899-1922; Miss Mary Agnew Snively (Superintendent of Nurses, Toronto General Hospital and Founder of the Canadian Nurses Association) was treasurer from 1899-1904, and was succeeded by Miss Margaret Bray (Great Britain), who acted in that capacity until 1925.

The present officers of the Council are:—President, Miss Nina M. Gage, China; first vice-president, Miss Clara D. Noyes, U.S.A.; second vice-president, Miss Jean I. Gunn, Canada; treasurer, Miss E. M. Musson, Great Britain; and secretary, Miss Christiane Reimann.

#### Congresses, Conferences and Meetings of the Council

Buffalo .....	1901	Congress.
Berlin .....	1904	Congress and First Regular Meeting of the Grand Council.
Paris .....	1907	Conference.
London .....	1909	Congress and Second Regular Meeting of the Grand Council.
Cologne .....	1912	Congress and Third Regular Meeting of the Grand Council.
Copenhagen .....	1923	Meeting of the Executive Committee.
Helsingfors .....	1925	Congress and Fifth Regular Meeting of the Grand Council.
Geneva .....	1927	Conference and Meeting of the Board of Directors.
Montreal .....	1929	Congress and Sixth Regular Meeting of the Grand Council.

In Berlin, 1904, the membership of the Council consisted of the three founder organizations, those of Great Britain, United States of America, and Germany.

In London, 1909, the national associations of Canada, Denmark, Finland and Holland were affiliated.

In Cologne, 1912, the national associations of India and New Zealand were affiliated.

In Copenhagen, 1922, the national

associations of Belgium, China, Italy, Norway and South Africa were affiliated.

In Helsingfors, 1925, the national associations of Bulgaria, Cuba, France, Irish Free State and Poland were affiliated.

The last Congress of the International Council of Nurses, held in Helsingfors, 1925, was attended by 1,100 nurses from 33 countries. The Conference held in Geneva in 1927 was the first meeting of the Council where the French and German languages were put on an equal basis with English. This meeting was attended by 700 nurses from 34 countries.

Practically all the distinguished women of the nursing world have taken part in the international meetings of the Council. Such nurses as Edith Cavell, Isla Stewart, Isabel Hampton-Robb, Baroness Mannerheim and Agnes Karll—not to mention all the prominent living members in the different countries—have been the source of inspiration to nurses from all five continents. It is impossible to tell how much the professional discussions at the meetings of the Council have influenced the standards of nursing legislation, ad-

ministration of nursing organizations, institutional management, introduction of preliminary courses for probationers, etc., in the various countries.

#### III

The Governing Board of the International Council, the Grand Council, is composed of (i) the members of the Board of Directors of the Council; (ii) four delegates from each of the nineteen affiliated coun-



tries; and (iii) one "associate national representative" from each of the eleven additional countries where the Council has such representation. The Grand Council meets regularly at each quadrennial Congress, but can be called together at other times if required.

The business in the intervals between meetings of the Grand Council is dealt with by the Board of Directors, which is composed of (i) the honorary presidents of the Council (Mrs. Bedford Fenwick, Mrs. Tscherning, Miss Annie W. Goodrich); (ii) the elected officers (president, first and second vice-presidents, treasurer and secretary); and (iii) the presidents of the affiliated national organizations.

The Council has, at present, 13 Standing Committees, on which the countries are represented as follows:

1. Education .....	30 countries
2. Public Health Nursing ....	30 countries
3. Private Duty Nursing .....	23 countries
4. Mental Nursing and Mental Hygiene .....	countries
5. Membership .....	3 countries
6. Programme .....	2 countries
7. Arrangements .....	1 country
8. Publications .....	5 countries
9. Nominations .....	3 countries
10. Revision of Constitution and By-laws .....	3 countries
11. Finance .....	3 countries
12. Florence Nightingale Memorial .....	5 countries
13. Study of Publications and Management of the I.C.N. ....	3 countries

The expenses incurred by the work of the Council—not including those connected with its Congresses and Conferences, for which the hostess association is responsible—are met by dues, each affiliated member organization paying yearly five American cents per capita of its active membership.

The Headquarters of the Council was established in Geneva, October 1st, 1925. It is situated in spacious quarters on the border of the Lake of Geneva, and its present staff, in addition to the secretary of the Council, consists of two assistant secretaries.

The work of the Headquarters—the object of which should be to create public opinion as well as to be of assistance to official and private organizations and to individual nurses—is as follows:—

1. Secretarial work in connection with the Board of Directors and the Standing Committees.
2. Information Service: the Council is approached by a great number of organizations—international and national, official and non-official—as well as by individuals. The total number of individual letters per month now amounts to about 400. This correspondence is carried on in ten languages.
3. Work in connection with Congresses and Conferences of the International Council and with exhibitions of various national and international associations, and attendance at meetings of other organizations.
4. Advice and assistance in procuring situations or opportunities for post-graduate study for trained nurses in other countries than their own. Within the last year Headquarters has thus assisted about 100 nurses of eight nationalities.
5. With regard to publications, Headquarters has hitherto, on account of the smallness of its staff, had to limit itself to its quarterly magazine, "The I.C.N.," which was started in 1926 (January), and to reports of its Congresses and Conferences. The last report was published in three languages and there are articles in three languages in the magazine. It is intended to issue different publications, the material for which has been largely collected already, as occasion arises.
6. Efforts are made to collect at Headquarters a good international nursing library. As regards current nursing literature the efforts must already be considered, to some extent, successful, as complete collections are found there of most of the 53 nursing magazines of a national scope—from their beginning and including all issues of recent years. In addition, there are about 50 magazines of special interest to nurses, such as publications for social workers, on hospital administration, etc.

Of nursing text and reference books there is a collection of about 500. The number of languages represented in the material found in the library is sixteen.

Photographs and pictures of prominent nurses and of nurses' meetings are also collected.

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.  
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### *The Training of a Public Health Nurse*

By EDITH KATHLEEN RUSSELL, B.A.,

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It is both desirable and necessary that the subject of the training of public health nurses should be freely discussed, but the task presents difficulties that make us hesitate long in the effort, and in this particular instance I find my pen so peculiarly reluctant that some explanation thereof must first be given. It is quite evident that some of the difficulties are inherent in the subject, and one of the chief is a lack of terminology that has general sanction. Such being the case, both the written and the spoken word are bound to create confusion whenever and wherever discussion is attempted. The very terms "public health nurse" and "public health nursing" are clumsy and confusing and lack precision of meaning, a very good indication of the diversity of concept underlying the spoken symbol. The difficulty thus suggested is increased by the fact that the readers of this paper represent many countries and therefore a wide variety of experience and practice. Recognizing that there is little common understanding upon this subject in any one country, it is evident that there will be much difficulty in attempting to generalize for such a wide-spread discussion. I shall merely remind my readers that, as I am writing from Canada and am in a position to speak authoritatively of Canadian procedure only, the latter must necessarily colour the argument here set forth.

In order to discuss the training offered for any type of work, it is desirable first to have a full knowledge of the work for which this

training is to serve as preparation. Therefore the logical introduction to this subject should consist of a description of public health nursing. The attempt to give such a description leads at once to the very heart of our problem, for it reveals the fact that this work, so vaguely described as public health nursing, is very varied. As the work of one country after another is reviewed, the bewildering fact emerges that no less than five distinct occupations are being considered in this connection, viz., bedside nursing, school nursing, midwifery, social work and health visiting (i.e. tuberculosis, child hygiene work, etc.) It is a far cry from the backblock nurse of New Zealand to the fursorgerin of Austria, and in between lie all the varieties of visiting nurse, health visitor, visiteuse d'hygiene, sestra pomocnina, etc., and all are meant to be included in this term "public health nursing." No wonder that we are puzzled in trying to give a description of the work. It will be well if the wise women of the profession will realize that all these pieces of work may be desirable, but that some are irreconcilable, and that compromise is necessary. It is also the part of wisdom to see that each country must work out the procedure that seems best suited to its needs and traditions and that extensive standardization is neither possible nor desirable.

#### *Existing Courses*

So much for the character of the work. Can we place beside that a general description of training

courses as they now exist? Here again there is much variety but, in spite of the variety, it is quite easy to pick out two predominant types of preparation. One method prepares first a hospital nurse, and then adds to the hospital nurse's equipment a hurried study of health work, begun and concluded within a period of one academic year. The other method makes a direct and continuous preparation of a public health nurse throughout a two-year (no longer) course, including in that preparation such hospital experience as is deemed of fitting proportion, both to the whole length of the training and to its main purpose. These two main tendencies in the method of training have more than passing interest because each one bears a relation, not primarily to the type of work for which the public health nurse is preparing, but rather to the nursing history of the country wherein it is found. The English-speaking countries with the older tradition in hospital nursing schools were bound to approach this preparation of the public health nurse by the circuitous route of the one-year, post-graduate course for hospital nurses; other countries, that had no system of nursing schools at the time when the demand for the training of public health nurses was first felt, were strangely enough in the much happier position of being able to meet this demand in a more direct and logical fashion. An interesting illustration of this point is found in the methods of public health nurse training now being conducted in a few French schools and other European countries which might also be cited in illustration of the same procedure.

The introduction to this discussion has covered, so far, two matters. The one is a recognition of the great variety of work for which public health nurses are preparing. The second is that training courses the world over, while displaying much

variety of detail, can nevertheless, be classified into two groups, the one offering an indirect method of preparation, and the other a direct method; that the indirect method of preparation is still the more popular of the two, and that this might be hard to understand were we not able to offer an historical apology for such procedure.

Turning back to the varied content of public health nursing, we find the most acute problem therein today is the question of whether this work is to include or exclude bedside nursing, and all development of training courses will be conditioned by the answer to this question. And yet who can answer it? For that we should need a new Solomon to sit in judgment. With all the diversity of opinion and practice there is, however, a strong tendency to combine the organized health activities of the public health nurse with some form of bedside nursing service. This tendency gives us cause to think that perhaps some day, after the present emergency needs have been met, the whole problem will be re-shaped. It is possible that the official field of public health work may reorganize itself with regard to the nursing service and that, consequently, the health visitor type of public health nurse may tend to disappear. When the happy day arrives in which the school teachers of the community are doing their work with adequate preparation for the task of health protection and health education, then the particular problem of school nursing may become much more simple and, if so, the combination of organized health work with bedside nursing will not present the insuperable obstacles that appear today.

#### *Bedside Nursing*

But to return to the present. Even today there is sufficient bedside nursing in the public health nurse's occupation to make it evident that training for public health nursing must include a thoroughly sound

preparation for bedside nursing. Note the demand that the training shall be good, for most emphatically it is agreed that there is no place in such work as this for poor craftsmanship. But having made this claim for good training in bedside nursing, I want to be equally emphatic in stating that such training need not, and should not, be given as preparation for hospital nursing. However, it is apparent that it will have to be given in a hospital, and the demand for this type of bedside training, in such exclusive terms, will indeed raise difficult problems for the hospital schools. I shall return to this thought later.

Having granted the need for a training (of some, as yet, undefined nature) in bedside nursing, we turn to the second and equally important aspect of our pupil's preparation, and that is a study of health, its conditions and requirements. Some at least of the studies thus indicated can be grouped under three headings, viz., 1. Physiological, fundamental to a scientific understanding of public health work; 2. Psychological, mental hygiene being so essentially and inextricably a condition of health; 3. Preventive, the specific contributions of bacteriology and immunology having made possible some of the chief triumphs of modern public health work. In the description of this aspect of the public health student's programme I wish to be brief. The outline is clearly indicated for us, but the detail must vary greatly, and no purpose could be served by discussing detail in a paper such as this. Thus we have noted the two chief elements of the preparation needed by our public health nurse. Let me repeat them. One is the training for bedside nursing and the other is a study of the science of health. There will be other aspects of the training, but these two are fundamental and this discussion can go no further afield.

#### *Arrangement of Programme*

The next question concerns the order of arrangement and relative demands in time of these two parts. My chief argument is that they should constitute one indivisible whole. Every economic, as well as every psychological reason, reinforces this demand. I should like to make firm insistence upon the necessary unity or integrity of this training by listing the following demands for it:

1. The course should start with a foundation which has but one purpose, i.e. it must be fundamental to public health work.

2. Each and every part should be added on as a preparation for public health work.

3. The whole should be maintained as a unit of studies and training in preparation for health work.

4. The appropriate attitudes required in the public health nurse should be taught consistently and persistently throughout.

5. At no point should the training digress from the preparation of a public health nurse.

All this would seem absurd repetition to the uninitiated, but to those who are informed, the repetition has meaning. Thus I have made my plea for a school in which the public health nurse may obtain an adequate training given as one whole. This plea is really the burden of my paper. The present one-year courses are trying to teach public health work in a few brief months to a group of students who have received no scientific foundation for an understanding of that work. The whole procedure is unsound and not to be tolerated longer than necessary. It is most unfair to the student who spends four years (three in hospital and one in the public health school) at her preparation and finds at the end of that time that she has no adequate foundation upon which to build knowledge, and, saddest of



all, finds (usually) that it is too late to turn back and obtain that foundation work.

As no discussion of the public health nursing course is allowed to ignore the enticing question of practice or, as it is commonly called, field work. I must not omit it altogether. But I can merely give passing reference to it while keeping within the limits set for this paper. The relative claims of theory and practice provide a subject for much debate, some of which is none too intelligent or intelligible. There seems to be some idea that a training course may, if made sufficiently practical, take the place in educative effect of a first year (or even many years!) of experience with a public health organization. Surely this is a wrong objective: training courses are meant to prepare for such experience, not to take the place of it. Field work is necessary and may be valuable, but no good purpose will be served by making absurd claims for it. The truth of the matter is that the whole question of the place of field work in the curriculum must depend upon one's attitude toward public health nursing and the type of worker wanted for it. Is it a technician who is wanted to perform mechanically certain routine procedures? If so, train her quickly by practice work. But if any understanding be wanted, and a scientific preparation, then experience and practice work must stand aside until time is given to lay this desired foundation. It cannot be done hurriedly.

The new four-year course (so-called), which was started last year in Toronto, is the expression of one effort to decide upon the full training needed by a public health nurse and to make that training available as one complete whole. In this experiment we could not hope to sweep away abruptly all previous tradition and custom, nor were we able to command sufficient equipment and

personnel to create an entirely new school. So we have, in the course, some work that is a concession to custom or to necessity and admittedly not placed there in the best interests of the pupil. The outline of the course is as follows: The first year is spent in the university at the study, with at least some brief degree of thoroughness, of certain foundation work in science. The second and third years (26 months exactly) are spent in the School of Nursing of the Toronto General Hospital, following the required training (with certain special arrangements) for that School's diploma in hospital nursing. The fourth year is spent at the university in a study of organized public health nursing. Thus it appears that in reality we have no four-year course, but rather two courses, each two years in length, and each given in a different institution. All that holds the two together is an agreement, which makes each of these two-year courses dependent the one upon the other. As far as possible the four years have been planned consecutively, but we cannot pretend that they form one whole. For the fact that it has been possible to start this new course we are indebted to the co-operation of the School of Nursing of the Toronto General Hospital, and particularly to the sympathetic understanding of the director of the school. That school has had to break through tradition, short but already powerful, and permit an alteration in the usual arrangement of time and content for the curriculum of these pupils. We have probably no right to ask more until we are very sure of the direction in which we must move. There is no university degree offered in connection with this course.

The matter of public health training will have to be faced seriously if we are reasonably sure that public health nursing is an occupation that will continue in some form in the

future and is one for which a fairly large group of workers is going to be needed. In time this will mean a serious problem for those countries that have the older tradition in hospital schools. With all the present difficulties pertaining to the preparation of a hospital nurse, they must face the demands that will thus come upon them to lend themselves, or rather their wards, for such hospital experience and teaching as may be needed by this person, i.e. the public health nurse in training. We hesitate to make any such demands upon the hospital schools before we have a very definite sense of the direction in which we should move.

Some critics may object to the discussion here set forth as savouring all of a narrow utilitarian or vocational attitude. Claims are made that certain so-called cultural subjects shall be added to the curriculum in order that the full personality (sic) of the student may be developed. It is hard to deal with such

aspects of the question in the few brief words still permitted me. Is it possible, though, to contend seriously that there need be any lack of cultural opportunity for the pupil who is pursuing the studies that have been indicated above? It is true that schools may or may not do much for their pupils in helping them to cultivate the finer things of the mind and spirit. But such things, if accomplished, are of the very essence of the school and are too intangible to appear upon a curriculum. In the description here given of a desirable training for public health nurses, we are assuming the existence of a school that is worthy of its name and opportunity.

(The World's Health, October, 1928.)

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**Correction:** We have been informed that "Development of Study Habits in the Student Group," as published in the December, 1928, issue, was written by Miss Ethel Sharpe, Royal Victoria Hospital, Montreal, instead of by Miss Elsie Alder.



—Courtesy of Canadian National Railways.

THE RODDICK MEMORIAL GATE  
Entrance to McGill University, Montreal

## Department of Private Duty Nursing

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### *The Nursing of the Mentally Sick*

By CLAUDIA M. FLEMING, Superintendent of Nurses, Nova Scotia Hospital, Dartmouth, N.S.

Mental diseases come under four classifications, i.e.:

1. **ORGANIC GROUP:** Diseases due to actual changes in the structure of the brain, changes which interfere with the function of the brain and produce a derangement of its normal action. Under this group come the senile psychoses, general paralysis, psychoses with cerebral syphilis, psychoses with brain tumor.
2. **TOXIC GROUP:** Mental diseases caused by toxins or poisons:
  - (a) Intoxication psychoses due to alcohol and drugs.
  - (b) Autotoxic psychoses.
3. **SOMATIC GROUP:**
  - (a) Infective psychoses — caused by the toxins produced by the micro-organisms of the infectious diseases.
  - (b) Exhaustive psychoses — brought about by severe and prolonged illness.
4. **CONSTITUTIONAL GROUP:** Functional diseases in which there are various symptoms of mental derangement, without any change in the structure of the nervous system to explain them. This group includes the manic-depressive psychoses, involution melancholia, dementia praecox, paranoia, epilepsy.

#### **Infective-Exhaustive Psychoses**

The infective-exhaustive psychoses may develop in any patient ill with typhoid fever, pneumonia, scarlet fever, puerperal fever, malaria, or influenza. As in all fever cases, the mouth and lips are very dry and the tongue coated. Sordes collect on the teeth, and the breath is foul. These conditions, if permitted to exist, give rise to hallucinations of taste and smell, which make the patient refuse food. The mouth should be cleansed thoroughly and regularly, the teeth brushed, and

the tongue cleaned. Lime juice, ice-cold, is a splendid mouth wash, while many of the antiseptic mouth washes are apt to damage the stomach if swallowed by the delirious patient. The lime juice does no damage and will prevent the condition of dehydration which so frequently accompanies fever cases.

Fluids are most beneficial; the toxins are diluted and the kidneys are not so likely to be damaged. Sometimes much persistent effort is required to get the patient to take the quantity of food and liquids required. Sometimes food is refused vigorously; it may be because the stomach is already filled with toxic material or the intestines impacted with faeces. The nurse should exhaust all means before reporting to the physician that she cannot get the patient to eat. To resort to feeding with stomach or nasal tube is to acknowledge weakness. The bowels must operate daily, if possible naturally, but it frequently happens that one or more enemas are required during the 24 hours. The fact that the patient's bed is often wet is no indication that the bladder may not be distended. The lower portions of the abdomen must be carefully watched.

The skin, which may be dry and hot, should be bathed and rubbed with alcohol daily. If the patient is very restless, bandage his knees, feet, elbows and hands to prevent bruises. The hot pack will promote rest and sleep. The use of normal saline, either subcutaneously or intravenously, is sometimes beneficial. If the patient's condition permits, which is seldom the case, a prolonged warm bath may be ordered. Do not allow the temperature of the water to go above 100 degrees F. If the patient shows any signs of collapse,

remove him to the bed, elevate his feet, and summon medical aid. Watch carefully that the patient does himself no injury.

The foregoing type of nursing is that which the general nurse is most often called upon to perform.

Other types of mental disease with which the nurse should be able to deal are involution melancholia, epilepsy, and manic-depressive psychoses.

### **Involution Melancholia**

This is a form of mental disease which occurs after middle life, and is characterized by an anxious depression, developing slowly and pursuing a prolonged course. The patient is irritable, anxious, fearful, often sad, and has delusions of persecution, misfortune, and self-accusation for some sin committed many years before, for which punishment must be endured. The patient may be restless and agitated, move about uneasily, pick and rub the face, or he may be mute and inactive. Most melancholic patients are suicidal.

The nursing procedure is rest in bed with a liberal diet. Food is often refused because of delusions, and there may be great difficulty in inducing the patient to eat. Endeavour to learn why the food is refused. If it is because the patient believes the food to be poisoned, let him see you taste it. Or you may serve boiled eggs, allowing the patient to break the shells. Sometimes when food is refused the patient claims that his stomach and bowels are paralyzed, for which delusion there may be a basis. The patient may suffer from chronic constipation, giving rise to unnatural sensations and causing him to labour under a false belief. Such a condition may be relieved by proper care of the bowels and a copious use of fluids where possible.

If the patient is confined to bed, the skin must be kept free from bed sores. When suicidal tendencies are present careful watch must be maintained. Remove from the room all articles which might be used for self-destruction. The windows should be guarded or stops placed so that the window will open only a short distance. Open fireplaces should not be used. The patient must not be permitted to go to

the bath room alone, as he may drown himself in the tub. The nurse should try to interest the patient in himself and to direct his thought and conversation along normal channels.

### **Epilepsy**

This disease is characterized by attacks of sudden disturbance of consciousness, with or without convulsions, and tends to mental deterioration.

The symptoms may be mild or severe. In the mild form, or *petit mal*, there may be a feeling of dizziness and temporary loss of consciousness, with or without muscular spasm, or there may be slight muscular twitching, with very slight momentary loss of consciousness, after which the patient proceeds with whatever he has been doing.

Grand mal is the type usually seen in hospitals. The convulsions are severe and unconsciousness is prolonged. The attacks are often preceded by an "aura" or warning, when the patient complains of unusual sensations, numbness, a peculiar taste, a bright light, etc., then cries out, and, losing consciousness, falls heavily, "as if shot". This disease was at one time called the "falling sickness". Injuries are frequent, because the patient, in falling, makes no attempt to protect or save himself.

The tonic stage immediately begins: the whole body becomes rigid, the jaws are fixed, the eyes open and staring, or rolled backward, and the face becomes increasingly cyanosed, due to the loss of the respiratory movements. This stage lasts but a few seconds and is quickly followed by the clonic stage, marked by convulsive action of all the muscles, mild at first, then becoming violent, then less severe, and finally ceasing. The body then relaxes and the patient lies unconscious, breathing heavily, and often frothing at the mouth. During the convulsion, the tongue is bitten and urine and feces are passed involuntarily. On regaining consciousness there is muscular soreness, headache, and confusion, during which certain movements may be automatically performed. While in this state of bewilderment some patients become dangerous.



Status epilepticus is a condition in which the convulsions are almost continuous.

One attack follows another with only short intervals between; consciousness is not regained; the temperature is high; the pulse and respirations are increased in rate, and exhaustion soon follows. Or the intervals between the attacks may lengthen, the convulsions become less severe, and recovery ensue. Status epilepticus may occur at any time during the course of the disease, although it usually proves terminal.

Instead of the convulsions there may be certain states which are known as the "equivalent". These may take the form of simple excitement, or of furor in which the patient becomes noisy, violent, destructive, even homicidal, and refuses food; or of dream states in which the patient is dazed, disoriented, and has hallucinations; or of ecstasy in which the patient is extremely happy, hearing beautiful music and seeing heavenly visions; or of automatic states in which the personality is different, and the patient has no memory of his former self, wanders away, engages in unfamiliar work, but lives and acts in such a manner as not to arouse suspicion that he is in an abnormal state.

In the intervals between attacks some epileptics are bright, good-natured, and able to carry on their regular work, but many others are irritable, egotistical, selfish, stubborn, abusive and quarrelsome, and frequently become angry upon slight provocation. The mental condition is gradually weakened, and sensation, perception, attention, and memory show impairment. Delusions and hallucinations may occur, but orientation is usually not disturbed.

In nursing epilepsy, carefully note the character of the aura and where the convulsions begin. Loosen the clothing about the neck and waist, so that the respiratory movements may be free. Place a cork, a padded mouth gag, or a clothes-pin between the teeth to protect the tongue from mutilation. If the attack begins while the patient is eating, try to remove the food from the mouth, and place the

head as low as possible to prevent asphyxiation and choking. If the patient falls to the floor, make no attempt to move him, but straighten the body and place it in the position in which least injury can be done. Place pillows or folded blankets or garments under the head and arms, hold the jaw forward, wipe the mucus from the mouth and let the convulsion work itself out. When the muscular movements cease, put the patient in bed, change the clothing, bathe the face, swab the mouth with antiseptic solution, and apply an ice bag or cold compress to the head.

Establish regularity in the diet, which should be of simple, easily digested foods served in limited quantity, for these patients tend to over-eat, to crowd and push the food into the mouth until they choke. Sometimes when supervision is relaxed a large bolus of food is aspirated, with fatal consequences. Give meat sparingly and serve a light evening meal, for attacks are more frequent at night, and indiscretions in diet will often produce them. Regularity in bathing and elimination is important. Constipation is a common ailment and seems to contribute in causing attacks. Give water freely to drink, for this is a valuable aid in elimination. In status epilepticus sedatives are given per rectum, and the nurse may have to administer chloroform to lessen the severity of the convulsions, but this is never done without an order from the physician.

### Manic-Depressive Psychoses

This disease is characterized by recurring attacks of acute emotional disturbance, elation or depression, without deterioration, and by recovery from the attack. The attacks are in one of four forms, manic (excited), depressed, mixed (comprised of both manic and depressed), and circular (characterized by a manic attack followed by a depressed attack).

With the manic attacks there is motor restlessness and general over-activity. The face is flushed, the eyes may be more or less injected, the mouth and lips dry, or the mouth may

be frothy from incessant talking; the skin feels hot and dry; the temperature may be slightly elevated and the pulse rate increased.

Emotionally the patient is happy and elated, and may be playful and mischievous, or combative and antagonistic. The patient's attention is easily distracted and his ideas are disconnected. He chatters incessantly. His conduct may be impulsive, violent, and destructive. The memory is not impaired, hallucinations are rare and fleeting, delusions few, and consciousness is clear except in great excitement, when there may be clouding and incoherence of speech.

Manic-depressive patients are kept in bed during the period of acute excitement, and are isolated in a room where quiet is possible and all sources of sense stimulation are reduced. Unnecessary furniture, pictures, and other articles should be removed and visitors excluded, except when authorized by the physician. Patients are so impressionable that the least sound, movement, or change is noticed and immediately calls forth some response. Special care should be given to the mouth, tongue and teeth, and the lips kept moist with glycerine or cold cream. The usual baths will relieve the dryness of the skin. The fingernails should be closely trimmed to prevent scratches. The diet should be generous, as in all cases of over-activity nourishment must be taken in sufficient quantity to make up the depletion. The patient is often too busy to eat, and to induce him to do so the nurse must use much perseverance. Utilize the factor of distractibility by diverting his attention, and spoon-feed him. Avoid irritating the patient. Do not enter into discussions and do not answer him sharply or sarcastically. Avoid answering questions which would lead to discussions by diverting the attention to something else or by asking a question which demands an immediate answer. Control the activity by suggesting some other occupation, and give no peremptory commands to desist or to do, for these strengthen the determination to persist in the undesirable activity and

make management much more difficult. Sharp answers, peremptory commands, discussions and conflicts frequently lead to violent attacks, for the power of inhibition is so diminished that the patient does the first thing that comes into mind without considering the consequences. Continuous baths and wet packs are usually prescribed by the physician to aid in reducing the excitement. Too often patients in a hospital receive the impression that the pack is a form of punishment. The nurse should do all in her power to banish this idea and to establish the correct one that it is a valuable measure of treatment which the physician alone prescribes. When continuous baths and packs have been used over a long period of time, the skin may become excoriated from the friction against the wet sheets and hammock, and measures must be taken to prevent this condition. Upon removing the patient from the pack, give a shower or sponge bath, dry the skin thoroughly, rub well with alcohol, and apply a dusting powder to any parts which are reddened. If there is evidence of rash or other unusual condition, the physician should be notified at once, as packs and baths may be contraindicated. Sleep is of the utmost importance, and the nurse should exhaust every means at her command to induce it. Only as a last resort should she make use of the drugs which have been conditionally prescribed. There is, perhaps, no surer test of good nursing than to be able to get one's patient comfortable and quiet without sedatives, and to sleep without hypnotics.

During the depressed attacks the skin looks dull and feels cold and moist; the hair is dry and the fingernails brittle; the temperature may be slightly subnormal; the pulse is slow; the tongue is coated, the appetite poor, and there may be anaemia and loss of weight, for in depression all the physical functions are lowered or diminished. The patient may complain of headache in the top of the head, a symptom which is always more severe in the early morning.

(Continued on page 98)

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *Industrial Nursing*

By K. S. PERRIN, Vancouver, B.C.

In attempting to outline my work with the British Columbia Telephone Company in the capacity of health supervisor, I am impressed with the knowledge that without the splendid co-operation, lively interest and ready sympathy and understanding of the company's officials, which my work has ever received, nothing or at best a very little could have been accomplished.

Due to the fact that telephone work is attended by no more hazards than one would expect to encounter in any large business office, there is small need for first aid service—the occasional foreign body to be removed from an eye; cuts, wounds or abrasions occurring outside of the office to be redressed; a sore throat to be painted—this about constitutes the sum total of the actual practical nursing. Home visiting of the sick has always been, and still is, done by the employees' advisor, so that in the appointing of a graduate nurse as health supervisor the company had in mind not so much the care of the sick as the prevention of sickness by the spreading of the gospel of positive health amongst its employees.

Conditions under which the operators, of whom there are 1,533, work are both pleasant and hygienic. The operating rooms are spacious and well ventilated; the working day of seven hours only is broken by means of 15 minutes' relief periods into shifts rarely reaching and never exceeding three hours. In addition to large, airy and attractively appointed rest rooms, where the girls congregate during lunch hour and rest periods to sew, read, play the piano or listen to the gramophone; where the newest dance steps are demonstrated and the latest fashion in dress displayed, there is in each of the larger offices a silence room provided with couches,

cushions and rugs, where those so inclined may rest undisturbed.

Many of the girls board, batch or live so far distant from the office that they are unable to go home for their lunch. To facilitate their procuring hot, light and nourishing meals at a very nominal charge there have been installed in each of the larger exchanges very up-to-date cafeterias, which are operated without any idea of even making them self-supporting, as the company carries one-third of the cost of provisions and is quite satisfied if the cafeteria can clear the remaining two-thirds. In this way, very substantial meals may be had for such small sums as fifteen and twenty cents.

This department offers splendid opportunities in the line of promotion of good health. In arranging the daily menus, which I make as varied and attractive as possible, the use of the protective foods is encouraged by supplying salads, tomatoes, lettuce, fresh vegetables and dairy products, at the lowest possible price throughout the entire year. The consumption of salads in our largest cafeteria has jumped from six or nine daily to forty, sixty or ninety per day. Meats and pastries have, to a great extent, given place to sandwiches, salads, creamed vegetables and fish; bran muffins and milk. From records kept over a two-month period we found that, following the display of posters advising the drinking of milk, together with a reduction of one cent in the cost of a glass plus individual advice given many of the employees, the consumption of milk as a beverage increased sixty per cent.

We feel, and rightly enough, proud of the type of girl employed by the company. Ranging in age from seventeen to twenty-five years they, for the most part, have come direct from

high school where they have spent two, three and in some cases four years. Some leaving school earlier have been employed elsewhere. Here I might say that it is most unusual for a girl to resign for any reason other than to assume the responsibilities of married life. Married women are employed only as temporary or all-night operators. When a girl marries she resigns.

The applicants, following their acceptance by the employment chief, undergo a medical examination by the company's doctor, after which they receive a month's tuition before being taken on the staff. It is as students that I give them a health talk along the lines of hygienic living, stressing in particular the importance of daily exercise and good posture. I find, upon interviewing the older employees, that dysmenorrhea and constipation are very common ailments and the accompanying history is almost invariably one of having either immediately or gradually given up all physical activity upon taking up telephone work. I try to impress upon them the fact that these conditions, together with anaemia and lassitude, are largely avoidable, arising from either ignorance or carelessness. I emphasize the importance of health in the creating of beauty, efficiency and advancement in their work.

During her first month of employment each girl reports at my office. This interview I make as informal as possible, learning from the individual much concerning her family history, previous illnesses, mode of living and attitude toward her work. A record is made of this, together with her height, weight, chest expansion, posture, condition of throat and teeth; symptoms of eye strain or nervousness are particularly noted. By means of a card index file these records are available for future reference. Again at the completion of eleven and twenty-two months' service the girls return to me, when I compare their present condition with their past record. We are thus en-

abled to keep a close check upon those whom we consider as requiring special attention, and in many cases have had them see their own physician, thus preventing more serious developments with a greater loss of time.

Again, girls are sent to me by their immediate superiors for the following reasons:

- (a) Irregularity of attendance, giving "ill health" as an excuse.
- (b) Lack of progress or interest in work, with "ill health" as the given cause.
- (c) Changes in appearance likely to have arisen from "ill health" or unhygienic habits of living.

Through the medium of a monthly magazine, published by the company for the benefit of the employees, I am able to reach those with whom I otherwise might never come in contact. I write a health article for each issue, emphasizing to the best of my ability the doctrine of prevention rather than cure. I point out the value of periodical medical examinations; the danger of patent medicines or any self-administered drugs; the value of a healthy, happy and fully occupied mind in the building of a healthy body.

Two years of positive health teaching affords too short a time for one to hope for any great results shown in the decrease of illness, but as time goes on if my teachings are to bear any fruit we should notice some sort of reduction in our list of absentees due to illness, and the absences should, on the whole, be of shorter duration. The fact that employees are sufficiently interested in their health to come voluntarily to be weighed and re-weighed if underweight; for advice in the prevention of or cure of colds; for the correction of improper elimination or painful menses, is in itself encouraging. The fact that there is a "trained nurse" to look after their health is, on the whole, greatly appreciated by the employees and to a still greater degree by their parents.



## Book Reviews

### NURSES, PATIENTS, AND POCKET-BOOKS

Further review of the book, "Nurses, Patients, and Pocketbooks," would seem a redundancy as well as almost an impertinence, since so many able reviews have already been published in American nursing and public health journals. It is only the fact that the subject matter is of such vital interest to Canadian nurses which justifies the space taken in our journal in the publication of an individual reaction to this book; and so important is the subject that it is to be hoped that not one but several Canadian nurses will write of their impressions upon studying its pages.

Before turning many pages, the questions most certainly occur: "Are conditions in nursing in the United States comparable to those in my country—Canada, France, England, or wherever my country may be; or are there in the United States a large proportion of what might be called 'commercial' hospitals—institutions owned by an individual or group of individuals which must be self-supporting and must presumably also make a financial return to their owners larger than in, for example, Canada, where there are very few hospitals owned by individuals and where a school of nursing in such a privately-owned institution is practically unknown? Is there, therefore, in the United States, in these privately-owned institutions, a greater danger of the exploitation of the student? Is there also in the United States less uniformity in the educational programmes of nursing schools?"

In order to properly evaluate the report, one should be familiar with the problems the committee is attempting to solve; we know it is not collecting facts and opinions in a haphazard manner. Such familiarity I cannot claim to any considerable extent. I am therefore considering the information rather from the angle of its value, or the value of similar details gained from similar sources in Canada, in helping to solve Canadian nursing problems. In view of the fact that the Canadian Nurses and Canadian Medical Associations are urging a study of nursing in Canada, a Canadian reader almost unconsciously questions: "Would we follow a plan similar to this or that, and are these facts or these opinions really worthwhile?"

The book, written by Dr. May Ayres Burgess, director of the "Committee on the Grading of Nursing Schools" in the

United States of America, is the report of the first of the three definite projects of the Grading Committee. These projects are stated as:

1. The supply and demand of nursing service.

2. What nurses need to know, and how they may be taught.

3. The grading of nursing schools.

This book is called a study of the "Economics of Nursing," and the apparent narrowing of the study of general "supply and demand" to that only of the supply and demand of nurses for private duty, and only with patients able to pay for such service, has made the report a very disappointing one.

Interesting predictions are made as to the probable number of nurses there will be in forty years, to each 1,000 physicians and for each 100,000 of the population, should the present rate of increase in the numbers of nursing schools and their graduate output continue. Valuable information is given in regard to the number and the size of the nursing schools, and the proportion of nurses graduating from schools conducted by the large and by the small hospital. While the committee has not yet directly sought information regarding the individual schools, or at least has not yet completed its first "grading" studies, sufficient information is given to indicate that there are wide variations in the educational programmes of the different schools; but the greater portion of the first part of the book is devoted to information gathered from physicians, patients, registrars, and the nurses themselves. Most interesting is the information gained from nurses in the various fields, and most of the answers suggest thoughts well worthy of study by those responsible for the conditions under which the different groups carry out the duties of their calling. One regrets the limited returns from such an important group as the private duty nursing group. It is realized that the returns from ten states should reasonably be regarded as typical, but only 35 per cent. of the private duty nurses in these ten states responded. Again, since the information given was based upon conditions of employment (or unemployment) during the preceding week only, realizing what a degree of variation there is in the work of private duty nurses, we must agree that the information is rather limited upon which to base any very sound conclusions regarding conditions of employment.

The information received from registrars did not appear to add very materially to a knowledge of the facts concerning supply and demand, and adds nothing to the facts concerning general community needs.

The section dealing with the opinions expressed by patients is, in part, anything but pleasant reading to nurses. It is a satisfaction, however, to remember that serious complaints were made by only twelve or fourteen per cent. of the patients who responded to the questionnaires: eighty-six per cent. of the patients stating that they would like to have the same nurse again. Some of the replies quoted evidently refer to the nursing situation in hospitals, not to care by the graduate nurse. Many will undoubtedly question the value of the information collected through these questionnaires; "opinions" we have had in the past, and we knew the source and could investigate the situation and evaluate their weight. Can we now accept more opinions from unknown sources as "facts"? As to some of the questions asked, many nurses will query the effect on the public, in its estimate of the nursing profession, when the Grading Committee would think it necessary to ask such a question as the one concerning gifts or "tips." One may question, too, the amount of space devoted to the recording of complaints, remembering that they represent the opinions of only twelve to fourteen per cent. of those replying. Since many readers will not take time to study the whole report in detail, is there a possibility of leaving wrong and very unfavourable impressions?

The information obtained from physicians indicates the interest of those replying, and indicates to a certain extent the number of nurses per physician who will probably, under present conditions, be required for private duty. Attention must, however, be drawn to the number of physicians who responded. To the first questionnaire sent to 38,000 subscribers to the American Journal of Medicine resident in ten states only 1,459, or four per cent., replied. To the third questionnaire sent to 19,200 of the 95,180 members of the American Medical Association, who had replied in the affirmative to the questions whether they frequently employed nurses and as to their willingness to reply to a questionnaire, only 2,882, or fifteen per cent., of the 19,200 responded. Thus, in all, less than four and one-half per cent. of the total membership of the American Medical Association replied to the questionnaires. Does this information add much to the facts already known? Does the lack of more numerous replies indicate that the medical profession at large feels that there is no nursing problem towards

the solution of which they can add any material aid? Have we the information upon which to base any sound conclusions?

The main source of disappointment, however, is that the study has left untouched the situation which seems to be of transcendent importance: that is a study of the nursing needs of the community, and the proportion in which these needs are being met. We know that the sick person in the poorest walk of life requires—to make the best recovery—nursing equally skillful to that required by a king or a president. With much talk of health insurance and state medicine, and with some such legislation already in force, are we justified in basing estimates of "demand" in the future upon present conditions of employment? Some time ago, reading a report of a visiting nursing organization which was carrying out a generalized public health programme, its estimate for the new year's work was based upon what it had not been able to accomplish in the community, not upon what it had done. Can we do less in the whole nursing programme? Lack of employment among both physicians and nurses has been shown in earlier studies to be largely a problem of distribution due to gravitation to the larger centres. No evidence to the contrary is presented here. It is undoubtedly essential that the laws of supply and demand must be studied, but it is equally true that the will of the people is to place "essential" services within the reach of all.

There are many interesting and valuable thoughts presented in Part II of the book in the comments and suggestions offered. In the chapter which comments on the Hospital and the Nursing School, attention is drawn to the need for serious study of the question, "Why is a school of nursing established"? All nurses will be in hearty agreement with the two principles which the Grading Committee has gone on record as holding:

1. "No hospital should be expected to bear the cost of nursing education out of the funds collected for the care of the sick. The education of nurses is as much a public responsibility as is the education of physicians, public school teachers, librarians, ministers, lawyers, and other students planning to engage in professional public service, and the cost of such education should come, not out of the hospital budget, but from private or public funds.

2. "The fact that a hospital is faced with serious financial difficulties should have no bearing upon whether or not it will conduct a school of nursing. The need of a hospital for cheap labour should not be considered a legitimate argument

for maintaining such a school. The decision as to whether or not a school of nursing should be conducted in co-operation with a given hospital should be based solely upon the kinds and amounts of educational experience which that hospital is prepared to offer."

The chapter on the nursing of the country patient and the plan offered as a solution of the problem appeal strongly to those who are familiar with rural problems. In many rural hospitals an attempt has already been successfully made to combine a limited health programme with the curative work of the institution. The fuller development of the public health side of the hospital's programme appears to present almost unlimited possibilities for community betterment, and will undoubtedly make such rural fields much more attractive to the well qualified nurse.

The material is all presented in a very readable way, and tables and graphs present very clearly the substance of the information which has been secured through the many questionnaires. Copies of all questionnaires are included in the appendix, and a report is made as to the response to each. This section must be carefully studied that one may evaluate the information presented and the author's conclusions and comments. That the study of the "demand" for nursing service is far from complete has already been commented upon. That the report is thought-provoking is evidenced by the number of comments from varied sources already published in the professional journals, and by the number of studies of local situations already instituted. The book deserves the careful study of all nurses, and especially hospital and nursing school administrators, and of all who have a part in the guidance of nursing affairs.

(Reviewed by Mabel F. Gray, R.N., Assistant Professor of Nursing, The University of British Columbia.)

**How You Began: A Child's Introduction to Biology.** By Amabel Williams-Ellis, with prefaces by J. B. S. Haldane. London: Gerald Howe; pp. 96. Price 2s. 6d.

Side by side the author has arranged an account of evolution and the story of embryology in such a way that children who can read will enjoy reading it for themselves and smaller children will listen to the story with the greatest enjoyment.

Most of us disagree with the old theory that biology is an unsuitable subject for small children. The problem has been how to present it to them to hold their interest. In this little volume parents, teachers, physicians and nurses have been provided with an almost ideal presentation of the subject for children. The story of embryology is a play story—how we played at being a fish or a furry animal, but only played because all the while we were intended to be something higher in the scale. The account of evolution is marked off in separate paragraphs and so may be read as a separate story quite as fascinating as its companion piece.

The reason for and value of such a book is well expressed by J. B. S. Haldane in the "Preface for Grown Ups" in the sentence "hygiene is applied biology and you cannot act hygienically if you have not learned to think biologically."

—H. C. C.

#### Pamphlets Received

Survey, Public Health Activities, Montreal, Canada, 1928. By the Montreal Health Survey Committee. Published by The Metropolitan Life Insurance Company.

Recreational Therapy in Convalescence and Allied Sub-Normal Health Conditions, by Frederic Brush, M.D., medical director, the Burke Foundation, White Plains, N.Y., sent through the Shirk's Fund.

Fourth Annual Report, 1927-1928, of the Montreal Anti-Tuberculosis and General Health League. A. Grant Fleming, M.C., M.B., D.P.H., managing director.

#### PHYSICIANS AND NURSES WARNED AGAINST COUNTERFEIT DRUGS

Action of the Board of Health in the City of New York uncovers the fact that a bold attempt has been made recently to put on the market spurious imitations of some standard pharmaceuticals.

These imitations closely resemble the genuine article. They are packed in similar bottles and cartons, with labels that are counterfeits of the originals, so that it is difficult to detect the fraud.

The New York Board of Health analyzed a number of specimens of these spurious articles obtained from various pharmacies. They demonstrated conclusively their fraudulent character and that the desired therapeutic effect could not be obtained by their administration.

Principal among the drugs which have been imitated is Luminal, the spurious tablets of which contained no phenobarbital but an entirely different drug.

The druggists who dispensed the counterfeits were brought into court and heavy fines were imposed. A warning has been broadcast to the retail drug trade to beware of these bootleg drugs and to refuse to accept standard preparations which are offered to them at unusually low prices by peddlers or irresponsible firms.

The therapeutic effect of Luminal is well known to the physician, and when he encounters a patient who does not respond in the usual way to the action of the drug his suspicions should be aroused. In such instances he should procure an original bottle of the product dispensed and send it to the Winthrop Chemical Company, 117 Hudson Street, New York, for analysis.

Your local board of health will also be anxious to hear of any attempts to perpetrate this fraud in your community.

## News Notes

### INTERNATIONAL COUNCIL OF NURSES

It can readily be imagined that during these months preceding the Sixth General Meeting of the Council, which will be held in Montreal from July 8th to 13th inclusive, that members of every organization of nurses in Canada are busily engaged in learning all information available concerning the Council. Also that they are studying and planning ways and means by which they can best assist our Committee on Arrangements with the preparation for the meeting and the entertainment of our guests.

Canadian nurses planning to attend the Congress are requested to aid the Committee on Arrangements by sending in their applications for accommodation at an early date, applications to be sent to: Committee on Arrangements, Royal Victoria Hospital, Montreal. The rates for rooms in the large hotels are as follows:

Single room .....	\$3.00—\$4.00
Single room with bath..	5.00—7.00
Double room .....	5.00—7.00
Double room with bath..	8.00—10.00
Large room, 3 persons....	7.50—10.00
Large room, 4 persons....	8.00—12.00

Rates for bed and breakfast in convents and boarding houses are from \$1.20 to \$1.50.

The Sub-Committee on Exhibits announce that applications for Exhibits space and the amount of space required should be made before March 1, 1929, to Miss C. M. Ferguson, Royal Victoria Hospital, Montreal.

### ALBERTA

CALGARY: We regret to announce the loss sustained by Mrs. Stewart Brown, honorary president of the Calgary Association of Graduate Nurses, in the death of her second son, Richard, at Hamilton, on December 31st, 1928, at the age of 20 years. Our deepest sympathy is with Mrs. Brown in her bereavement.

### MANITOBA

GENERAL HOSPITAL, WINNIPEG: Miss Gertrude McMullin (1920), has left to spend the winter months in California.

Miss Grace Bedford (1920), in company with her father is spending the winter in California.

Miss Sadie Bentley (1920), has left for New York City.

Misses I. McKinnon and M. Macrae (1911), are relieving in the General Hospital, Dauphin, during Miss K. Cotter's (1905) absence in California.

Miss Elsie Wilson (1915), of the Provincial Board of Health staff has left for California where she will spend several months.

Miss R. Fogarty (1898), had the misfortune to fracture her arm early in December.

Mrs. P. Weims (1926), has resigned her position in charge of the Children's Ward and has left for the States.

Miss Evelyn Hall (1912), of Sinaluta, Saskatchewan, spent a few days in the city early in the New Year.

Sympathy is extended to Miss Erma McLeod (1928), in the death of her father in December, and to Mr. and Mrs. Welch, of Boissevain, in the sudden death of their daughter Marjorie (1928), within a few days of the completion of her training.

BRANDON: The December meeting of the Brandon Graduate Nurses Association was held at the home of Mrs. Sharpe. Dr. Maud Robertson, of Boissevain, gave an interesting paper on "Problems of the Private Duty Nurse." Refreshments were served, and an enjoyable social hour spent.

Miss C. Lynch, superintendent of nurses, Brandon Mental Hospital, has returned after attending a post graduate course at Bloomingdale, N.Y.

### NEW BRUNSWICK

CHIPMAN MEMORIAL HOSPITAL, ST. STEPHEN: Miss Grace Moffat, of Sherbrooke Hospital, has been appointed superintendent of the Chipman Memorial Hospital. Miss Buchanan, her assistant for a short time, has resigned to accept a position as superintendent of Laurentian Sanatorium, St. Agathe, P.Q. Miss Sinclair who has been night supervisor, is taking Miss Buchanan's place temporarily, and Miss Myrtle Dunbar is night supervisor.

Miss Hazel Darker, supervisor of operating room, is spending her vacation at her home in Sherbrooke, P.Q. Miss Maxine Johnson is taking her place during her absence.

Miss Nellie Spinney is spending her holidays with her mother.

Miss Irene Sherrard has gone to Claremont, N.H., to do floor duty in the hospital there.

A recent business meeting of the local chapter, New Brunswick Association of Registered Nurses was held in Miss Moffat's suite, after which the members enjoyed a social hour.

SAINT JOHN: Much sympathy is extended to Misses Mary Clarke (General Public Hospital, 1926), and Hazel Reicker (General Public Hospital, 1927), in the deaths of their fathers.

Miss Frances Day of the staff of the General Public Hospital is ill, and her friends hope for a speedy recovery. In her absence Miss Isabelle Richardson has taken over her duties.

Friends of Miss Alice Cousins are glad to know that she has sufficiently recovered to resume private practice.

Misses Mary Walsh and Margaret Higgins (St. John Infirmary), have gone to New York to take institutional positions there.



## NOVA SCOTIA

**HALIFAX:** There was held in December at the Nurses' Home at the Victoria General Hospital a well-attended meeting of the Alumnae Association of the Victoria General Hospital, with the president, Miss Ethel Warner, in the chair. The outstanding matter for discussion and action was that of perfecting arrangements for a bridge party to raise a fund to be contributed to the general fund for the great conference of the International Council of Nurses, which is to be held in Montreal next summer, and will assemble in the Canadian metropolis hundreds of finely representative members of the nursing profession from many different countries.

Recently, the Lord Nelson Hotel was the scene of a very delightful tea given by the Nova Scotia Registered Nurses Association in honour of Miss Mary Watson, Superintendent, Yarmouth Hospital, an efficient officer, who is shortly leaving the Province on an extended and well-earned holiday.

Every member of the executive was present, anxious to do honour and express regret at the loss of so valued a member. Among the guests was Miss Caie, secretary of the Yarmouth County Hospital Association, accompanied by Miss Anna Young. An interesting visitor was Miss Mitchell who has given seventeen years valiant service in China.

Miss MacIsaac, matron of Camp Hill Hospital, poured tea, and delicious refreshments were served by a bevy of nurses. Miss G. Strum, superintendent of Victoria General Hospital School of Nurses, Miss Carson, superintendent of the Children's Hospital, Miss Fleming, of the Nova Scotia Hospital, Miss Margaret Mackenzie, of the Provincial Department of Health, Miss Fenton, superintendent of the Dalhousie Public Health Clinic, and Miss Campbell, superintendent of the Victorian Order of Nurses, were present.

This function was made the occasion of a presentation to Miss Watson of a leather wardrobe hat box on behalf of all, by the president, Miss Catherine Graham, who expressed their keen sense of loss at the impending separation, their appreciation of Miss Watson's sterling qualities of mind and heart, her forgetfulness of self, when duty called, and her splendid efficiency, as exemplified in her profession, recalling the fact that when Miss Watson took charge of the Yarmouth County Hospital it was a cottage of a few beds, and greatly due to her capable leadership it is today an up to date accredited institution. In closing, the president extended sincere good wishes from every nurse in Nova Scotia to Miss Watson for her future happiness and success, wishing her God speed in all her undertakings. Miss Watson's reply, though brief, was tinged with much feeling, obviously this demonstration of confidence, esteem and affection on the part of her sister nurses was deeply and heartily appreciated by the recipient.

The afternoon was a happy one in spite of the shadow of severance hovering near.

**YARMOUTH:** On the occasion of her resignation of the superintendency of the Yarmouth Hospital, which her ability brought to a high state of efficiency from insignificance, Miss Watson had a remarkably flattering proof of the regard which she has inspired. The presentation function was held at the Grand Hotel, Yarmouth, in the presence of the leading people of the community—in respect to its representative character it was a remarkable gathering. The first gift presented was from the Board of Directors, and consisted of a solid ivory box, bearing her initials in monogram. It contained twenty shining \$10 gold pieces, and the address which accompanied it gave unqualified expression to regard. From it "The Mail" quotes but a small part which, however, will indicate its sincerity and warmth: "It is very hard—indeed it is impossible—to put into formal phrase the sincerity and warmth of feeling which so many of the people of this town and county, and of the adjoining counties entertain towards you for the skilful, patient and sympathetic service given by you in your capacity of superintendent of the Yarmouth Hospital; service personal to many of them, or to their immediate relatives or friends. It was surely something more than an accidental circumstance that when in response to an advertisement published by this society seventeen years ago asking for applications from persons qualified to act as superintendent of our small cottage hospital, you applied for the position, and it was certainly a fortunate choice when the directors selected your application from among several then before them. This has been demonstrated by the splendid quality of the service given by you, and by the nurses under your charge, and still more by the unusual executive ability, and untiring devotion to the work which in spite of so many hindrances and difficulties have contributed so largely to the development of the institution from such a small beginning into the fine buildings and equipment of the Yarmouth Hospital as we find it today. In leaving us you are leaving behind many sincere friends, whose best wishes for your future welfare and happiness will follow you, and it seems reasonable to believe that you will always retain a warm feeling of kinship with the institution here which owes so much to you." By the Ladies' Aid Society of the hospital, Miss Watson was presented with a gold mesh bag, and by leading physicians through Dr. G. W. T. Farish, with an exquisite diamond dinner ring. Each gift was accompanied by an enthusiastically appreciative address, Miss Watson being very visibly affected by the spontaneity and generosity and good will.

#### ONTARIO APPOINTMENTS

The following appointments have been made:

Miss Emily Groenawald (Women's College

Hospital, Toronto, 1928), anasthetist in one of the leading dental offices in Toronto.

Miss Amy Hayward (Women's College Hospital, Toronto, 1928), assistant supervisor at a Red Cross outpost, St. Joseph's Island, Northern Ontario.

Miss Gertrude Finnemore (Women's College Hospital, Toronto, 1928), Red Cross work at Cohill, Ontario.

Miss Adele Cameron (Toronto General Hospital, 1926), charge second floor, Private Patients' Pavilion, Toronto General Hospital.

Miss Frances Charlton (Toronto General Hospital, 1924), charge Emergency Department, Toronto General Hospital.

Miss Winnifred McCunn (Toronto General Hospital, 1927), charge of Ward "I," Toronto General Hospital.

Misses Hope Heggie (Toronto General Hospital, 1926), Clare McConnell (1927), Florence Moore (1927), and Ruth Ames (1928), floor duty, the Pavilion, Toronto General Hospital.

Misses R. Belanger, Jeanne Cardinal (Ottawa General Hospital, 1928), supervisors of Maternity and Surgical floors respectively, at the Jeanne d'Arc Hospital, Montreal.

Miss Archange Labelle (Ottawa General Hospital, 1925), supervisor, Maternity Department, St. Mary's Hospital, Ottawa.

Miss G. Briand, assistant superintendent of nurses, St. Mary's Hospital, Ottawa.

Miss Emily Fallis, charge, Men's Surgical Ward, Ottawa Civic Hospital.

Miss Marion C. Woods (Ottawa Civic Hospital, 1926), and post graduate of Post Graduate Hospital, New York City, operating room supervisor in Grace Hospital, and Miss Doris L. Kent (Grace Hospital, 1927), assistant.

#### DISTRICT 2

GENERAL HOSPITAL, BRANTFORD: The December meeting of the Alumnae Association was held in the Nurses' Residence. Miss Dora Arnold, president, occupied the chair. The speaker of the evening was Mrs. Scott ("Happy" Day), a former graduate of the Brantford General Hospital. For the past eight and a half years, Mrs. Scott has been active in the mission fields of India, of which she related her experiences in a most interesting way. Special attention was drawn to the high mortality rate, and of the dreadful conditions surrounding midwifery of that country.

Her most enlightening address was much enjoyed by all, and a very hearty vote of thanks was tendered her. Miss Robinson presented Mrs. Scott with a handsome brass tabouret as a slight token of the high esteem in which she is held, accompanied by the good wishes of all present.

An interesting feature of the evening was a cup and saucer shower.

Refreshments were served by the social committee under the capable convenership of Miss Annabelle Hough.

#### DISTRICT 4

ST. CATHARINES: The regular monthly meeting of the Mack Training School Alumnae was held December 5th, 1928, at the

Leonard Nurses' Home. The regular business meeting was followed by a musicale and tea.

The Registered Nurses of District 4 held their regular quarterly meeting on November 24th, 1928, at St. Catharines. The meeting opened with the singing of "O Canada" and usual preliminaries—the president in the chair. A most interesting report of the general meeting C.N.A. was given by the delegate and secretary, Miss Eva Moran. Miss MacIntosh, convener of the District, was called upon to discuss the ways and means by which the District could raise funds for the International Congress.

During the supper hour a very pleasing musical programme was given. Following this a most enlightening illustrated travel talk—"A Month Spent Abroad," was given by Dr. W. J. MacDonald, of St. Catharines.

#### DISTRICT 5

WOMEN'S COLLEGE HOSPITAL, TORONTO: Miss Bertha Arksey (1928), awarded the Public Health Scholarship, is at present attending the University of Toronto.

Miss Mabel Jones (1928), has been awarded the Indian Medal for highest marks obtained by any Indian nurse in training in Canada this year. This entitles the recipient to a post graduate course in Public Health Nursing in New York City. Miss Jones intends to take the course this spring.

HOSPITAL FOR SICK CHILDREN, TORONTO: The Alumnae held a most successful meeting on December 11th, 1928, which took the form of a Christmas party and shower, each member bringing a gift of some sort to be distributed among the less fortunate. Donations became so numerous, that they overflowed the tables, and were in piles on the floor.

Games that tested the ingenuity of nurses were played, and the prize for the "Medical Spelling Match" was won by Miss Crosby, and for the "Smelling Contest," by Miss Murdoch—music, musical chairs and refreshments brought the evening to a close. A very large number were present.

GENERAL HOSPITAL, TORONTO: Miss Janice McKinnon (1924), is spending the winter in Florida.

Miss L. Shannon (1922), of Detroit, visited in Toronto during the Christmas season.

Miss Olive J. McNee (1922), has left Yonkers, N.Y., and is doing floor duty at St. Luke's Hospital, New York.

GRACE HOSPITAL, TORONTO: From letters received from Miss Hilda Duckworth (1927), from England, it is learned that she is being sent to a mission centre in Duzdab, Persia, instead of to India, as she at first expected. She sailed from England for Persia on January 4th, 1929.

#### DISTRICT 8

GENERAL HOSPITAL, OTTAWA: Miss A. Blant is taking a post graduate course in pediatrics at Columbia University, New York City. On completion of this course Miss Blant will accept a position in the sanatorium at Three Rivers, P.Q.

**CIVIC HOSPITAL, OTTAWA:** Miss Evelyn Horsey has resigned from the staff to take post graduate work in pediatrics at the Children's Hospital, Boston.

The nurses enjoyed a very splendid Christmas Tree party among themselves the Saturday before Christmas, and the annual Christmas dance was held at the Nurses' Home on December 28th, 1928.

Through the generosity of the Hospital Trustees the nurses have been presented with a splendid Electrola and a "Radiola 60."

#### DISTRICT 9

**STONE MEMORIAL HOSPITAL, PARRY SOUND:** The Graduation Exercises of the Stone Memorial Hospital, were held in the hospital parlours on December 28th, 1928, when two nurses received their diplomas: Misses Dorothy B. Cole and Verna M. McCullough. The Florence Nightingale Pledge was administered and diplomas presented by Mr. H. E. Stone. Rev. Mr. Turner very ably presided, while appropriate addresses were given by Rev. Mr. Brydon, Rev. McCurlie and Captain Calvert, followed by a Prayer of Consecration by Rev. Mr. Miller. The programme included delightful vocal and instrumental solos.

Miss Dorothy Cole, a recent graduate of the Stone Memorial Hospital has accepted a position on general duty in a hospital in Brooklyn, N.Y.

#### DISTRICT 10

The annual meeting of District 10, R.N.A.O. was held in McKellar Hospital Nurses' Home, Fort William, December 6th, 1928, with 36 nurses present. Dr. A. T. Gillespie gave an interesting address on the "History of Medicine." The following officers for 1929 were elected: Chairman, Miss Jane Hogarth, Fort William; Vice-Chairman, Miss Anna Boucher, Port Arthur; Secretary-Treasurer, Miss R. Wade, Port Arthur. Final arrangements were made for the bazaar which was held on December 17th, the proceeds of which amounted to \$250.00.

McKellar Hospital Alumnae held their December meeting in the home of Miss Vera Lovelace, Port Arthur, 16 nurses present. Following an interesting and instructive paper on Laryngectomy by Miss Doris Dow, who has just recently returned from taking a post graduate course at the Manhattan Eye, Ear, Nose and Throat Hospital, the meeting took the form of a Christmas party, each nurse receiving a gift from the Christmas tree. A committee was appointed to buy anything required for the Alumnae Ward in the McKellar Hospital, which was furnished in 1923 by the Alumnae as a memorial to their beloved superintendent, the late Miss Isabel Johnstone.

Misses A. Simpson and E. Ellis, Port Arthur General Hospital, 1928, are taking a post graduate course at the Royal Victoria Hospital, Montreal.

#### QUEBEC

**ROYAL VICTORIA HOSPITAL, MONTREAL:** On New Year's afternoon Miss Hersey and staff were at home to all R.V.H. graduates

and their friends. The guests, numbering about one hundred and fifty, were received by Miss Hersey. Mrs. Stanley and Miss Goodhue presided over the tea table.

Miss Clarice Smith (1926), has returned to Montreal and is doing private nursing.

Miss Isabella Goodearle (1924), is in charge of a medical floor at the Medical Centre, New York.

Miss Stella Byrne (1925), is in charge of Corner Brook Hospital, Corner Brook, Newfoundland.

Mrs. Alan B. Taylor (Mary Byers, 1918), was a recent welcome visitor at the R.V.H. after an absence of several years in Durban, South Africa.

Christmas greetings were received at the R.V.H. from Mrs. Archie Crawford (Mary Pickard, 1922), Beirut, Syria.

Many friends will be glad to hear that Miss Frances Pendleton (1920), is recovering after a recent serious illness.

Misses Ann Sparling and Jane Wheaton (1924), have joined the staff of Guelph General Hospital.

The annual meeting of the Alumnae was held January 9th in the Nurses' Home. The following officers were elected for the year: President, Mrs. Stanley; First Vice-President, Mrs. LeBeau; Second Vice-President, Mrs. Scrimger; Treasurer, Miss Burdon; Recording Secretary, Miss G. Martin; Corresponding Secretary, Miss K. Jamer; Conveners of Committees: Finance, Miss Enright; Programme, Mrs. Scrimger; Sick Visiting, Miss Gall; Representative "The Canadian Nurse," Miss E. Flanagan; Local Council of Women, Misses Hall and Yeats; Private Duty Section, Misses Steel, McCallum, Palliser and McKibbin.

It was unanimously voted to give the sum of \$1,000 towards the fund for the International Congress to be held in Montreal in July.

At the close of the meeting a platinum bar pin was presented to Mrs. Roberts, retiring recording secretary, in appreciation of her many years of faithful service in that office. After the meeting refreshments were served.

Miss Adelaide Sims (1898), has resigned her position as superintendent of Kenogami Hospital to be near her brother Dr. Bert Sims who is seriously ill. Miss Sims is now at 27 Sussex Street, Ottawa.

Miss Ethel Burns (1922), is spending the winter in St. Petersburg, Florida.

**GENERAL HOSPITAL MONTREAL:** The following appointments have been made: Miss Sarah Bell-Fraser (1928), charge, public floors, C and D, Montreal General Hospital.

Miss L. L. Best (1927), staff, Women's General Hospital, Westmount, P.Q.

Miss Phyllis Tremaine (1927), office nurse with Dr. Walsh at Medical Arts Building, Montreal, P.Q.

At the December meeting of the Alumnae Association, Miss Cramp, of Montreal, gave a very interesting illustrated lecture on the life and work of Michael Angelo.



A number of Montreal General Hospital graduates spent their Christmas holidays at their respective homes.

Miss Lucrecia Stewart (1925), is with the Provincial Department of Public Health Nursing, at Virden, Manitoba.

Sympathy of the members is extended to Miss Dorothy Jones (1928), in the recent loss of her mother.

The engagements of Misses Beryl Campbell (1928), to Mr. Russell Pikaart, Belleville, New Jersey; and Anna Marie Le Blanc (1927), to Mr. Edward Ney-Smith Christison, have been announced.

Miss Frances Upton resigned from Laurentian Sanatorium, St. Agathe des Monts, on December 15th, 1928, to take up her duties as Executive Secretary for the Arrangements Committee of the International Council of Nurses, the beginning of January, 1929, with her office at Royal Victoria Hospital. Miss Mildred Buchanan succeeds Miss Upton at St. Agathe. Miss Juana McCosh has taken a position in the same institution.

Error in last month's items of Montreal General Hospital, stated Miss Doris Stevenson (1928), had taken charge of operating room at Children's Memorial Hospital, Montreal, instead of Montreal Children's Hospital.

### SASKATCHEWAN

The first issue of the Monthly News letter of the Division of Public Health Nursing, Department of Public Health, appeared in December.

Miss K. M. Ross (Regina General Hospital, 1915), recently of British Columbia, has accepted the position of superintendent of nurses, Regina General Hospital, and assumed her new duties in December.

Miss Elizabeth Cameron, Carman, Manitoba, has taken charge of the Red Cross Outpost at Bracken, replacing Miss Shantz, resigned. Miss Gladys Black, Moose Jaw General, who has been assistant at Bracken, took charge of Lucky Lake, January 1st, replacing Miss Johnson, resigned.

Miss Mark (Saskatoon City Hospital), has gone to the Red Cross Outpost at Kelvington.

Miss Elizabeth Farquharson (Regina General Hospital), who has been in charge at Wood Mountain, resigned January 1st, to be married early in 1929.

We are sorry to report the serious illness of Miss L. Noble, who is a patient in the Saskatoon City Hospital.

KERROBERT: Recently Miss Mabel Stowe resigned her position as matron of the Kerrobert Union Hospital. Previous to her departure Miss Stowe was presented with a Royal Crown Derby tea set by the citizens of Kerrobert, and with a silver tea service from the staff nurses of the hospital.

PRINCE ALBERT: Prince Albert Graduate Nurses Association lost a very faithful

member in the death on December 15th, 1928, after a long and trying illness, of Mrs. Wm. M. Traill (Frances Eleanor Fortescue, Montreal General Hospital, 1897-98), who was instrumental in the founding of the Association and, until prevented by illness took an active interest in all concerning it, and attended regularly at all meetings. She had many thrilling tales to tell of her experiences doing private duty under most primitive conditions and in the Boer War. Married eighteen years ago she spent those years in Prince Albert helping with Red Cross Nursing classes and other activities, and always in touch with those who were actively engaged in nursing. The deepest sympathy of the association is extended to her husband and daughter.

QUEEN VICTORIA HOSPITAL, YORKTON: Graduation Exercises were held on December 18th, 1928, when diplomas were presented to: Misses Kathryn Isabel Abel, Marie Augusta Lee, Katie Louise Shibbom, Olive Roberta Peake, Tomera Ramsay, Anna May Sperce, Cora Ellen Gibney, Nedra Elizabeth Cockwill. Miss Lee was awarded the general proficiency medal. A reception was later held in the City Hall.

### VICTORIAN ORDER OF NURSES

A Regional Conference for Board members, arranged by a Sub-Committee of the Central Board of the Victorian Order of Nurses, was held at the Connaught Hotel, Hamilton, on January 15th.

The programme for the day included: a discussion topic, "Interlocking Relationships in Health Service," and brief papers presented by Dr. Grant Fleming, of Montreal, Dr. Roberts, of Hamilton, Misses E. H. Dyke and Ethel Greenwood, of Toronto. The session closed with a brief dramatization of the nurse's entrance to the home.

Misses Amy Holden (Victoria General Hospital, Halifax), and Faye Saunders (Areostock Hospital, Houlton, Me.), have been appointed to the staff in Halifax.

Miss May Siebert has resigned from the V.O.N. in Gaspé, P.Q.

Miss Dora Ashkins (Dawson Memorial Hospital), has been appointed as second nurse in New Glasgow.

Mrs. Dubeau (St. Vincent de Paul Hospital, Sherbrooke), has been appointed to the staff in Cornwall.

Miss Margaret Clements (Children's Memorial Hospital, Montreal), has been appointed to the staff in Galt.

Miss Grace Whiesell (Ottawa Civic Hospital), has been appointed as second nurse in Pembroke.

Miss Dorothy Driffield (Montreal General Hospital), has been appointed to the V.O.N. in Smith's Falls to fill the place left vacant by the resignation of Miss Ethel Laird.



## BIRTHS, MARRIAGES AND DEATHS

## BIRTHS

ARMSTRONG—On January 7, 1929, at Calgary, Alberta, to Mr. and Mrs. R. Armstrong (Alma Mercer, Calgary General Hospital, 1921), a daughter.

BISSON—On November 17, 1928, at Ottawa, to Mr. and Mrs. Bisson (C. Landry, Ottawa General Hospital), a son, Earl Francis.

BOULDING—On December 16, 1928, at Calgary, Alberta, to Mr. and Mrs. E. F. Boulding (Rachel Moran, Grey Nuns' Hospital, Regina, Saskatchewan), a son.

BOYD—Recently, at Edmonton, to Mr. and Mrs. R. J. B. Boyd (Royal Alexandra Hospital, Edmonton), a daughter.

BROWN—On January 2, 1929, at Collingwood, Ontario, to Mr. and Mrs. Horace Brown (Bernice Strathy, Toronto General Hospital, 1924), a son.

CHALMERS—On January 5, 1929, at Sudbury, Ontario, to Mr. and Mrs. Alan Chalmers (Agnes Connor, Toronto General Hospital, 1923), a daughter.

DOODY—On December 2, 1928, at Regina, Saskatchewan, to Mr. and Mrs. Doody (Alice Peake, Regina General Hospital, 1924), a daughter (Elizabeth Alice).

DRINNAN—On December 16, 1928, at Calgary, Alberta, to Mr. and Mrs. Andrew Drinnan (Nan B. D. Hendrie, Toronto General Hospital, 1921), a daughter (Rona Helen Blackwood).

ECKFORD—On December 17, 1928, at Calgary, Alberta, to Mr. and Mrs. Eckford (Laura K. Hunter, Toronto General Hospital, 1922), a son (Douglas Charles).

HIGGINS—On December 9, 1928, at the Brandon General Hospital, to Mr. and Mrs. S. Higgins (Ida Little, Brandon General Hospital, 1925), a daughter.

McKAY—On December 14, 1928, at Cessford, Alberta, to Mr. and Mrs. W. A. McKay (Miss Paynter, Winnipeg General Hospital, 1911), a daughter (Verna Theodora).

O'GORMAN—On November 17, 1928, at Ottawa, to Mr. and Mrs. O'Gorman (Irene Ripar, Ottawa General Hospital, 1920), a son (Thomas).

## MARRIAGES

BURLEIGH—HEISLER—On January 1, 1929, at Lunenburg, Nova Scotia, Mary Belle Heisler (Montreal General Hospital, 1928) to Reginald W. I. Burleigh.

COMSTOCK—CLARK—On January 1, 1929, at Rosebud, Alberta, Helen Margaret Clark (Calgary General Hospital, 1928) to Lester Comstock, U.S. Ranch, Rosebud, Alberta.

DICKESON—WOODSWORTH—On December 11, 1928, at Edmonton, Alberta, Marion Josephine Woodsworth to Donald Dickeson.

JOHNSON—HOBSON—Recently, Phoebe Hobso (Royal Alexandra Hospital, Edmonton, 1928) to Evald Johnson.

JOY—LANGFORD—Recently, Isabel Langford (Winnipeg General Hospital, 1925) to Rev. Mr. Joy, of Dinsmore, Saskatchewan.

KEMP—NIXEY—On December 10, 1928, at Prince Albert, Saskatchewan, Winnifred Nixey (Victoria Hospital, Prince Albert, 1928) to Rex Kemp.

KILBOURN—McKAGH—On January 5, 1929, at Toronto, Mary Elizabeth (Betty) McKagh (Toronto General Hospital, 1924) to William Quay Kilbourn, of Owen Sound, Ontario.

KILLINS—MACGREGOR—On December 31, 1928, at Kirkland Lake, Margaret MacGregor (Royal Victoria Hospital, 1926) to Roy Killins.

MAGUIRE—DELANEY—Recently, at Saint John, N.B., Mary Delaney (Saint John Infirmary, 1929) to John Maguire, of Spencer, Mass.

MICHIE—BURRY—On November 10, 1928, at Edmonton, Alberta, Christine M. Burry (Royal Alexandra Hospital, Edmonton, 1926) to Dr. Thomas Campbell Michie, of Nanaimo, B.C.

MONAHAN—LEONOWENS—On November 15, 1928, at London, England, A. H. Leonowens (Montreal General Hospital, 1919) to Dr. Richard Monahan.

PLANCHE—CASS—On November 12, 1928, at Sawyerville, Carol Cass (Jeffery Hales Hospital, Quebec, 1925) to Harold Planche.

RUSSELL—STEWART—On January 7, 1929, Anne Stewart (Montreal General Hospital, 1928) to James G. Russell, of Cap Chat, P.Q.

SNIDER—NELSON—On December 22, 1928, at Toronto, Ontario, Anne Laidlaw Nelson (Grace Hospital, Toronto, 1921) to Dr. Roy James Snider, of Thessalon, Ontario.

SOMERS—HENDERSON—On November 28, 1928, at Saskatoon, Saskatchewan, H. G. Henderson (Saskatoon Children's Hospital, 1924) to W. E. Somers, M.D., of Foam Lake, Saskatchewan.

SUMNER—HARRIS—On January 1, 1929, at Burks Falls, Ontario, Martha Agnes Harris (Montreal General Hospital, 1926) to William Dixon Sumner, of Montreal.

WILSON—GAYMAN—On December 8th, at St. Catharines, Ontario, Anna A. Gayman (Mack Training School, St. Catharines, 1927) to Maurice Wilson.

WOODS—VAN DUZER—On December 28, 1928, at Toronto, Frances Van Duzer (Toronto General Hospital, 1922) to W. H. Woods.

### DEATHS

EATON—On December 20th, 1928, at the Royal Victoria Hospital, of pneumonia, Mary Judson Eaton (Royal Victoria Hospital, 1922).

Wanted: Registered nurses for general duty in two hundred and fifty bed Tuberculosis Sanatorium. Seventy-five dollars per month with full maintenance. For further particulars apply to: M. L. Buchanan, Matron, Laurentian Sanatorium, St. Agathe des Monts, P.Q.

Wanted: Superintendent of Nurses, college woman preferred; experienced in Training School administration, Midwest hospital. Position open April 1st, 130 beds, salary \$125.00 with complete maintenance. Requires a woman of real efficiency and experience. Apply Box 135 The Canadian Nurse, 511 Boyd Bldg., Winnipeg, Man.

The Frontier Nursing Service has positions for Public Health Nurses certified under a British Central Midwives' Board. Because of waiting list, applications must be received several months in advance. For further particulars, address the Director, Mrs. Mary Breckinridge, Wendover, Leslie County, Kentucky.

### THE Manitoba Nurses' Central Directory

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Insurance statistics over a period of five years show an increased mortality of 40% above the normal death rate for the five years following an epidemic of Influenza.

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(Continued from page 86)

A melancholy emotional attitude is the most outstanding mental symptom. The patient moves little and slowly, sits alone and pays little attention to what is going on about him, for his thoughts are centred in himself. Delusions of unworthiness and self-accusation are common, and suicidal tendencies are invariably present. In severe cases psycho-motor retardation becomes prominent and is accompanied by a feeling of insufficiency. The patient has few ideas, and thinks, speaks, and moves slowly and with difficulty. The depression may be so profound that the patient becomes stuporous, fails to respond to ordinary stimuli, assumes catatonic-like positions and makes no voluntary movements. This condition causes the heart action to become weak, the pulse slow, the temperature subnormal, and the skin and extremities cold.

Patients suffering from depressed attacks are put to bed until their physical and mental condition shows improvement. Watchfulness to prevent suicide is the most important nursing measure. The nurse must not leave the patient alone, nor allow him to appeal to her sympathies to the extent of allowing him more freedom. It is sometimes necessary, especially after visits and recreation, to search the clothes, the bed, and the room for articles secreted for the purpose of self-injury or destruction. The search should be made in such a way as to avoid the disclosure of distrust and lack of confidence.

The patient's room should be sunny and cheerful, with bright hangings, books, magazines, flowers, etc. The food should be attractively served, and the patient given every inducement to eat it. He may refuse it because he thinks he does not deserve it, or has no money to pay for it, or will deprive others who need it more, or because he wishes to starve himself to death. If all other means of inducing the patient to eat fail, the physician must resort to tube feeding. Insomnia must be combatted and the patient kept warm. Massage is a tonic and stimulates the circulation, and the salt glow is also prescribed for its tonic effect.

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# The Canadian Nurse

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## MARCH 1929

### CONTENTS

### PAGE

THE INTERNATIONAL COUNCIL OF NURSES' CONGRESS - - - -	115
FOUNDER AND OFFICERS, THE INTERNATIONAL COUNCIL OF NURSES - -	116
OUR PROFESSIONAL OBLIGATIONS - - - - - <i>Jean E. Brown</i>	121
MISS ANNA C. MAXWELL - - - - -	123
MATERNITY MORTALITY - - - - -	125
THE IMPORTANCE OF THE SOCIAL LIFE OF THE STUDENT NURSE - - - - - <i>Beatrice Creasy</i>	128
PROGRESS AND OPPORTUNITIES IN THE FIELD OF NURSING - - - - - <i>A Student Nurse</i>	130
MISS ANNIE J. HARTLEY - - - - -	132
DEPARTMENT OF NURSING EDUCATION:	
THE STATUS OF NURSING AMONG FRENCH-CANADIANS - - - -	133
VOCATIONAL GUIDANCE - - - - - <i>Grace M. Fairley</i>	137
DEPARTMENT OF PRIVATE DUTY NURSING:	
HOURLY NURSING - - - - - <i>Margaret L. Moay</i>	138
DEPARTMENT OF PUBLIC HEALTH NURSING:	
FIGHTING DIPHTHERIA IN NEW BRUNSWICK - - <i>Huilota Dykeman</i>	143
A HEALTH EXHIBITION IN AUSTRALIA - - - <i>Elinor N. Wade</i>	144
BOOK REVIEWS - - - - -	145
NEWS NOTES - - - - -	147
OFFICIAL DIRECTORY - - - - -	155



# International Congress of Nurses

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Plans for the Congress of the International Council of Nurses to be held in Montreal, July 8th to 13th, are maturing rapidly. The following is a summary of arrangements to date:—

**HEADQUARTERS:** The Montreal High School, University St., Montreal.

**REGISTRATION:** The registration bureau will be at headquarters. Registration will begin on July 5th and continue throughout the following week.

**TRANSPORTATION:** Reduced fares on the Identification Plan will be available for Canadian nurses attending the Congress.

Arrangements are being made with the president of each Provincial Nurses Association to issue identification Certificates.

Any nurse wishing to take advantage of the reduced fare must apply to the president of her Provincial Association for her Identification Certificate which must be presented when purchasing ticket to Montreal.

Round trip tickets at fare and three-fifths will be issued.

For some sections of Canada the Summer Tourist Fare or the usual Summer Rate may be less expensive than the Identification Certificate plan.

Information regarding dates of sale for tickets, and the names of those responsible for issuing Identification Certificates will be given later.

**RESTAURANTS:** Information regarding restaurants will be available at headquarters. Meals outside hotels need not cost more than 50c to 75c for breakfast, 75c for lunch and \$1.00 for dinner.

**PROGRAMME:** The convener of the Programme Committee has announced that the programme will soon be ready for publication.

**EXHIBITS:** It is considered advisable that all exhibits should be in Montreal not later than May 15th. It will be a great help to the Exhibits Committee

if all cases are clearly marked for the section to which they belong, viz.—Nursing Education, Public Health, etc. An inventory of the contents and instructions regarding their arrangements should be enclosed with the exhibits.

The exhibit room is to the left of the main entrance to headquarters, and can also be entered from the street.

The committee hopes to meet all requests for space and urges exhibitors to state clearly the amount of space desired when making application.

Address exhibits to Miss C. M. Ferguson, Convener of Exhibits Committee, Royal Victoria Hospital, Montreal.

**SOCIAL AFFAIRS:** Arrangements are not completed but those already planned include a visit to Ottawa, and a reception at Government House for the Grand Council, and a garden party on the last day of the Congress for the entire Congress membership.

**MEETING PLACES:** The Forum will be used for the large General Sessions.

The Montreal High School will be used for meetings of the Nursing Education Section, and rooms will be reserved here for special meetings of nurses from affiliated countries.

The Mount Royal Hotel will be the meeting place for the Public Health Section.

The Windsor Hotel will be the meeting place for the Private Duty Section.

**INFORMATION:** An Information Booth will be maintained at Headquarters, and will be open every day until 11 p.m.

A list of Convention members will be available for nurses wishing to locate friends.

**SIDE TRIPS OF INTEREST:** Information regarding interesting places to visit in and near Montreal will be placed in the folder given to each nurse on registration.

The Sub-Committee on Housing for the Congress announces that the supply of single rooms in the large hotels is now exhausted, but there are still a number of single rooms for reservation in private homes and in boarding houses, and a limited number in the smaller hotels.

Nurses who are planning to attend the Congress and who have not yet made reservation for accommodation are requested to do so without further delay.

While the single room accommodation is about exhausted there are still available in the large hotels a number of large rooms which will accommodate two, three or four. These hotels with rates are:

**MOUNT ROYAL HOTEL** (all rooms have baths):

2 in a room-----	\$ 7.00 per day.
3 in a room-----	9.00 per day.
4 in a room-----	10.00 per day.

**WINDSOR HOTEL:**

2 in a room—	
With bath	\$8, \$9 or \$10.00 per day.
Without bath-----	6.00 per day.
3 in a room—	
With bath-----	10.50 per day.
Without bath-----	8.25 per day.
4 in a room—	
With bath-----	12.00 per day.
Without bath-----	10.00 per day.

**PLACE VIGER HOTEL:**

3 in a room—	
With bath-----	\$ 9.00 per day.
Without bath-----	7.50 per day.
4 in a room—	
With bath-----	\$10.00 per day.
Without bath-----	8.00 per day.

N.B.—Rates quoted above are for the room and not per person.

Rooms will be available in private homes and in boarding houses at the rate of from \$1.50 to \$2.00 per night per person. Rooms in small hotels will be about \$2.00 to \$2.50 per night per person.

Convents will be able to take care of quite a large number of nurses at from \$1.25 to \$2.00 per night per person, including breakfast at prices

quoted. Accommodations will be beds in either dormitories or double rooms. The Y.W.C.A. has rooms at the same rates as the Convents.

Nurses coming in autos will find ample parking space.

**PLEASE NOTE:** It is necessary that each nurse when making application for accommodation state her name, address and official position. Application with this information should be made **at once** to the Executive Secretary, Committee on Arrangements, International Council of Nurses, Royal Victoria Hospital, Montreal, P.Q.

### Mrs. Bedford Fenwick

Mrs. Bedford Fenwick, Founder and Honorary President of the International Council of Nurses, and President from 1899-1909. As Miss Ethel Manson, she entered the Children's Hospital, Nottingham, as a paying probationer in 1878, and some months later became a paying probationer at the Royal Infirmary, Manchester. At the age of twenty-four she was appointed Matron and Superintendent of Nursing at St. Bartholomew's Hospital, London.

Following her marriage to Dr. Fenwick in 1887, she became interested and active in promoting an organization for the registration of nurses under state authority, and it was largely through her efforts that this was finally secured in 1919. For more than forty years Mrs. Fenwick has been actively engaged in strenuous public duty, first working for the Royal Charter for the Royal British Nurses Association, and from 1893 as the Honorary Editor of *The British Journal of Nursing*. The policy of this journal has been largely responsible for the demand for legal status throughout the world, for higher technical and practical education for nurses in their service to the sick, and for high standards of public health. Mrs. Fenwick is President of the National Council of Nurses of Great Britain and President of the British College of Nursing.

In 1897 Mrs. Fenwick acted as superintendent of a corps of nurses selected to go to Greece during the



MRS. BEDFORD FENWICK

Greco-Turkish war, and while there she was inspector of nursing at the Ecole Militaire Hospital in Athens, where she was awarded the Distinguished Order and Diploma of the Greek Red Cross.

She was President of the Society of Women Journalists, 1910-11, and has served as a member of the Grand Council and Executive Committee of the Territorial Army Nursing Service of the City and County of London.

In 1892 she visited the World's Fair in Chicago as a member of the Women's Committee of the British Royal Commission. There she received two medals and diplomas "for excellence of scientific exhibits," for an exhibit arranged by her in the Women's Building. At that time she met and conferred with a number of American nurses, with the result that the idea of an international organization of nurses was originated. These conferences eventually resulted in the

formation of the International Council of Nurses in 1899, which in less than thirty years has federated the self-governing national organizations of nurses throughout the world.

In 1928 Mrs. Fenwick reached her Jubilee of fifty years' professional work and service as a member of the nursing profession. The closing paragraph of an editorial comment on this Jubilee, published in *The British Journal of Nursing*, was, "Good health and high spirits are the blessings for which Mrs. Fenwick thanks God, which have made life for her a splendid experience, and it is these combined blessings she wishes humanity to enjoy to the fullest extent, and which women engaged in the privileged profession of nursing have largely in their power to promote."

### Miss Nina D. Gage

Miss Nina D. Gage, President of the International Council of Nurses since 1925, has been associated with nursing in China since 1908. In 1905 she graduated from Wellesley College and entered the School of Nursing, Roosevelt Hospital, New York. Miss Gage



MISS NINA D. GAGE

reached Shanghai late in December, 1908. With the thoroughness which has characterized her entire profes-

sional life she studied the Chinese language for six hours each day for the next two years, except during an illness from typhoid fever and an enforced stay in Japan of a few months owing to rice riots in Changsha. In 1912, Miss Gage was able to begin her work in earnest, and the double nursing school at Changsha was formally opened in December, 1913.

During these years she helped to organize the Nurses' Association of China, of which body she was president for two years. As there was at that time no government which could function in licensing professional people in China, the Association undertook the registration of schools, examination of candidates, planning the curriculum for the creating of a nursing profession. In 1913, the College of Yale-in-China entered into co-operation with the government of the province of Hunan to conduct medical education. The Chinese were to provide running expenses for the nursing and medical schools and hospitals, while the college was to provide the faculty. In this way the Hunan-Yale School of Nursing was opened formally, having had before that only a few pupils and no funds. From this time the school had its own budget.

Miss Gage returned to the United States in 1917-1918 on leave, when she studied at Teachers' College, Columbia University. Following her return to China Miss Gage became Dean of the Hunan-Yale School of Nursing, which was opened to college women, on a combined nursing and arts course, in 1921. In 1924-1925 she was again on leave, when she obtained her Master of Arts degree at Teachers' College.

Shortly after her return to China following the Congress of the International Council of Nurses in 1925, all the schools in the province of Hunan were broken up. Early in February, 1927, hospital and school work had become impossible and Miss Gage returned to New York City, where she became Educational Director of the Willard Parker Hospital.

Then in 1928 she was appointed Executive Secretary of the National League of Nursing Education.

### Miss Clara D. Noyes

Miss Clara Dutton Noyes, who is First Vice-President of the International Council of Nurses, is National



MISS CLARA D. NOYES

Director of the American Red Cross Nursing Service. This Service maintains a nursing reserve for the Army and is also available for the Navy and other Government Services and for the American Red Cross.

Miss Noyes is Chairman of the National Committee on Red Cross Nursing Service, which heads up a group of 197 Local and State Committees of nurses, which are responsible for stimulation of interest in the enrolment.

Miss Noyes is a graduate of the Johns Hopkins School of Nursing. She has been Superintendent of Nurses at the Hospital for Women and Children, Boston, Superintendent of St. Luke's Hospital and School of Nursing, New Bedford, Mass., and General Superintendent of Bellevue and Allied Schools of Nursing, New York City.

Miss Noyes has been active in many national organizations, and has held many important offices, including President of the National League of



Nursing Education, President of the Board of Directors of the American Journal of Nursing and President of the American Nurses Association, of which she is still a Director. She has been a steady contributor to nursing magazines, and edits the Department of Red Cross Nursing in *The American Journal of Nursing* and *The Red Cross Courier*. Miss Noyes is Chairman of numerous committees, among which is the Advisory Committee of the American Nurses' Memorial School at Bordeaux, France.

### Miss Jean I. Gunn

Miss Jean I. Gunn was elected Second Vice-President of the International Council of Nurses in 1925. She graduated from the School of Nursing, Presbyterian Hospital, New York City in 1905, and remained on the staff of that hospital in different positions for the next six years. At this time, Miss Gunn took up Social Service work and was employed in this branch of work in New York City for two years when she resumed institutional work. For a short time she was Assistant Superintendent of the Memorial Hospital, Morristown, New Jersey, and left that institution to take her present position as Super-



MISS JEAN I. GUNN

intendent of Nurses of the Toronto General Hospital in the Fall of 1913. Miss Gunn has held a number of

offices in professional nursing organizations and was Secretary of the Canadian Nurses Association, 1914-1917,



MISS ELLEN MARY MUSSON

and President of the same Association, 1917-1920. In addition to professional work, Miss Gunn served on the Executive of the Ontario Division of the Canadian Red Cross from 1918 until 1927, during which time she also served as the Chairman of the Advisory Nursing Committee. In 1928 she was appointed to the Executive of the Central Council of the Canadian Red Cross Society, and has served during the past year as Honorary Advisor in Nursing to the Canadian Red Cross Society.

### Miss Ellen Mary Musson

Miss Ellen Mary Musson, C.B.E., R.R.C., S.R.N., Treasurer of the International Council of Nurses, is a graduate with a gold medal of St. Bartholomew's Hospital, London, England. Afterwards she served as Ward Sister and Assistant Matron under the late Miss Isla Stewart, following which she held several execu-

tive positions as Matron, Swansea General and Eye Hospital, and the General Hospital, Birmingham. She was a Principal Matron of the Territorial Force Nursing Service. Miss Musson is Chairman of the General Nursing Council of England and Wales, and Chairman of the Registration Standing Committee. She is a member of the Collège of Nursing, is active in many of the nursing organizations in England and Wales. For the past three years Miss Musson has lectured on Training School Administration to the International Students of the League of Red Cross Societies, and for several years was an Externe Examiner for the Diploma in Nursing of the University of Leeds. Miss Musson is on the Panel of Examiners for the Diploma in Nursing of the University of London, and was appointed to the rank of Commander of the Order of the British Empire by His Majesty the King in January, 1928.

#### Miss Christiane Reimann

Miss Christiane Reimann was elected Secretary of the International Council of Nurses in 1922. She was born in Copenhagen and graduated from the Bispebjerg Hospital in 1916. The next two years were spent in post graduate study, including the several special branches in nursing which were then receiving for the first time the serious consideration of nurses. From 1918 to 1921, Miss Reimann was in the United States, first in the Presbyterian Hospital, New York City, and then at the Henry Street Settlement of New York, with some time spent in travelling all over the continent. During this time she attended two general sessions and one summer session at Teachers' College, New York, where she obtained the B.Sc. degree and diploma in teaching in schools of nursing.

Miss Reimann then returned to

the Bispebjerg Hospital, Copenhagen, where she had the honour to be appointed the first instructor in nursing



MISS CHRISTIANE REIMANN

in Denmark. Later, some time was spent in study at St. Thomas' Hospital, London, and again at Teachers' College where she obtained the Master of Arts degree in 1925.

From 1922 to 1925, Miss Reimann carried on the secretarial work of the Council in conjunction with her studies and since international headquarters were established in Geneva, in the autumn of 1925, she has conducted the work there.

Miss Reimann has already proven her inestimable value to the Council; she speaks several languages, has travelled and come in contact with nurses in many countries, and is possessed of a clear and forceful mind, animated with a great desire to assist nurses and nursing, which already has promoted the welfare of national and international nursing to a marked degree.

## *Our Professional Obligations*

By JEAN E. BROWNE, Toronto

The profession of nursing, if regarded from the point of view of service only, is a very old one indeed, as old at least as Christianity, but from the point of view of service based on scientific knowledge, it began about fifty years ago. The ideals with which the pioneers of fifty years ago imbued this new profession for women have influenced it to the present day in spite of great changes in scientific and social development, chiefly, I think, because those pioneers asked themselves the question "what can I give to it," rather than "what can I get out of it." It is because these unselfish ideals have persisted that you and I are proud to belong to the profession of nursing today.

Now, I don't propose to preach a sermon but rather to direct a little searching inquiry in which I hope you will all participate. First of all we may as well face the fact that there are rumours that all is not well with us. It is true that many of the assertions bandied about by our critics are based on loose thinking and loose talking, but when the smoke that comes from misrepresentation of facts has cleared away, I wonder if there is a spark of truth remaining in these criticisms.

You all know that there is at present functioning in Canada a Joint Committee of the Canadian Medical Association and the Canadian Nurses Association appointed to conduct a study on nursing in Canada. The members of the Committee are unanimous in their opinion that a scientific survey should be made. It is estimated that a sum of \$30,000 will be necessary to conduct such a survey, and, at present, the Committee is concerned in getting this money.

You are perhaps aware that a scientific survey of nursing has been

under way in the United States of America for over two years, and recently the Committee responsible has issued their first publication, "Nurses, Patients and Pocketbooks." This book should be read by all nurses for it contains some very salutary truths. This book deals first of all with the lack of understanding between the medical and nursing profession and reveals the fact that neither profession is informed about the other.

To quote from the book on this subject: "Physicians who, after leaving medical college, have had experience in hospitals which are proud of their high grade nursing service, carry out with them into the field something of an understanding of what good nursing can contribute to the recovery of the patient. Medical students, sometimes even before their hospital experience, learn something about nursing from the more thoughtful of their teachers, or even occasionally, in the very modern school, from regularly planned nurse instruction. Sometimes physicians out in the field learn through practical experience the difference between a woman who is merely kind and willing, and a woman who is a skilful nurse; but apparently there are large numbers of physicians who, never having had extended hospital experience, or other special contacts with really skilful nurses, have only the vaguest notion of what the nursing profession regards as its important contribution to the care of the sick. There is nothing in the ordinary medical course, or in the ordinary medical practice afterward (not even in the fact that a man gives ten lectures a year to student nurses) which miraculously makes a physician an authority on nursing. He must have known real nurses before he can intelligently talk about them. Probably there are some physicians who have never seen an example of good nursing in their lives.

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(Address delivered at the Annual Meeting of District No. 1, Registered Nurses Association, London, Ontario, January, 1929.)

"Many nurses are about equally uninformed as to what medical education implies. Some of them would have greater sympathy for physicians, and a better understanding of the problems they are facing, if they did know a great deal more about the processes of medical education. The outstanding difference between the two professions, however, is that, while nurses never worry very much about how the medical student is trained, physicians are continually concerned over the education of the nurse. And many physicians are not and never have been sufficiently close to nursing to make them safe advisers on so difficult and technical a subject.

"It has, then, seemed of first importance to the Grading Committee that a careful study be made of the fundamental facts which must lie at the basis of nursing education, and of the economic facts surrounding the employment of nurses, so that physicians and nurses could have immediately available a common basis for discussion. The Committee is convinced at the close of its first eighteen months of study, even more definitely than it was at the beginning, that physicians and nurses are fundamentally in agreement. They are working for the same purpose—the welfare of the patient—and where there seems to be conflict between the two groups the difficulty does not arise from warring principles, but is rather based upon lack of understanding of the facts involved. The Committee hopes that in presenting the data which follow, it may be rendering a real service to both the nursing and medical professions, and therefore, of course, to the patient."

But this aspect of our nursing work is only a part of the picture. The Committee sent a large number of questionnaires to the patients themselves and their replies are illuminating. Some have nothing good to say, but others (and they are the ones we ought to consider) have serious faults to find. One reply reads thus: "She was a lady and a nurse. She was one who made you feel you were safe

in her care." I should like to know personally the nurse about whom that was said. I do not intend to quote the other kind of replies, but I should advise all nurses to read them.

The cost of receiving proper nursing care is, I think, at the bottom of the discontent both on the part of patients and physicians. The unthinking patient and physician are very apt to blame the high cost of nursing on the nurses themselves, but it is manifestly a stupid thing to do, for it is a general economic problem which should be the responsibility of the whole community and not of nurses alone. But the nurses will have to help solve it. The two things of a practical nature that seem to emerge from this survey so far are "group nursing" in hospitals and "hourly nursing" in homes to meet the needs of that largest class of people in any community, the families living on an income of \$2,500 a year or less. There is at any rate a possibility of building up this hitherto unmet need and thereby giving more employment to nurses, while at the same time supplying a type of nursing service which would be genuinely valued and readily paid for by the community.

The chapter in this book on the Hospital and the Graduate Nurse is one of the most interesting in the book. The Committee has made the discovery that there is an ominous threat, in the way things are going on, of a startling overproduction of nurses, and the suggestion put forward is for a general consideration of Hospital Boards to engage graduate nurses to nurse the patients in hospitals.

The thing that one likes about this book is that it is not dogmatic, but it reveals certain alarming conditions and says: "What are we going to do about it?"

Canadian nurses must realize that the situation in nursing is not at all the same as it was fifteen years ago. The world is not at all the same as it was in 1914. Greater social and economic changes have taken place since 1914 than occurred in half a century before that. We talk rather



glibly about the traditions of our noble profession. But what are those traditions? First and foremost, I should say that the great thing that the pioneers in nursing did was to face the situation that existed in their time, to think clearly through the problems as they saw them, and then to apply themselves courageously, vigorously and unselfishly to solving them. We are only weaklings if we rest on their oars. We must be willing to face the present day situation which is different from what it was fifty years ago, or twenty-five or fifteen years ago.

The nurse who isn't willing to give some of her time and thought and interest to further her profession through its organizations is unworthy of her calling. Perhaps we older nurses are somewhat to blame for the apparent lack of interest on the part of young graduates, for we may give

the impression that the last word has been said, that nursing as a profession is complete, and no more remains to be done. Let us rectify this state of affairs as soon as may be, for never since its inception has our profession been faced with more serious problems. We need the view-point and enthusiasm of the young graduates and they no doubt need our experience. I'm quite sure we need each other in the next few years which, I believe, are going to be crucial in the history of the profession of nursing.

Now, I have not suggested to you any ready-made solution for the problems which I have mentioned. I haven't any, and I doubt if anyone else has, but I do know that if we pool our intelligence and our devotion in an honest, co-operative attempt to solve these problems, that we cannot fail to make a contribution of really great value to our profession.

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### *Miss Anna Caroline Maxwell, R.N., M.A.*

Miss Anna Caroline Maxwell, dean of American nurses and noble gentlewoman, whose greatest work during a period of over forty years was the training of nurses, died on January 2nd at the Presbyterian Hospital, New York.

Miss Maxwell's brilliant career covered the period during which nursing has become a recognized profession. She received her training at the Boston City Hospital under Miss Richard's direction, following which for a brief time she undertook the administration of the Montreal General Hospital. Later she took charge of the Training School for Nurses at the Massachusetts General Hospital. From there she went to St. Luke's Hospital, in New York, where she established a training school, and then in 1891 she went to the Presbyterian Hospital in New York, where she organized the school for nurses. There Miss Maxwell remained until her retirement thirty years later, in 1921. It is gratifying to remember that appreciation of the development

and progress of that school under her leadership was shown in 1928, when the nurses' residence of the New York Medical Centre was named in her honour, the Anna C. Maxwell Hall.

An American newspaper says: "She had not the austerity of Strachey's 'Lady with the Lamp,' but she had as compelling a way, queenly in dignity, firm and demanding, yet most gentle, gracious and kindly. She had her brief Crimea in the Spanish War, when she got the oft-quoted citation from an officer who did not welcome her coming: 'When you came we did not know what we would do with you. Now we do not know what we could have done without you.' She was ready to go to France for active service in the war, but the regulation as to age prevented and the services she could give at home were considered even more valuable, though she made one or two inspection trips to France."

From the *Public Health Nurse* we quote: "A career, begun so early, continued so uninterruptedly and devoted to those immense and exhaust-

ing difficulties somehow inherent in our early training schools, is remarkable in itself. But Miss Maxwell's energies and devotion overflowed into many additional channels. Out of her unique experience, her native sagacity, her unrivalled social charm, and her warm and generous heart, she gave without stint to the many causes and crises which sprang up in affairs of the great and growing profession to which she considered it an honour to belong. It will perhaps never be possible to estimate how much American nurses owe to her influence and devotion. Her services in furthering nursing education were recognized by the Governors of Columbia University, who in 1917 conferred upon her the Honorary Degree of Master of Arts".

*The American Journal of Nursing* records another honour conferred on Miss Maxwell in these words: "Another ceremony, however, was abandoned because of her failing health. An official presentation had been planned whereby a representative of the French Government should award the *Medaille d'Hygiene Publique* to four women who had made conspicuous contributions in the American nursing profession to the advancement of nursing throughout the world. Miss Maxwell was to have been the principal recipient at the ceremony. Instead of the elaborate formality which had been arranged for this event, a simple ceremony took place in December, 1928, beside Miss Maxwell's bed.

"A hand-illuminated parchment, setting forth the citation of the French Government, and a gold medal were presented to her by Dr. Charles Burlingame, Chairman of the Advisory Board of the American Hospital in Paris. . . .

"Thus in the school to which she had given thirty years of active leadership did Miss Maxwell receive her final recognition of achievement, and there, a month later, she died. The school that meant so much to her mourns her passing as a daughter grieves for the loss of her mother. Her name is carved in stone over the entrance to the new school residence, that stately pile which towers above the sweep of the Hudson where the medical centre vies with the palisades in impressive dignity. But deep though this carving be, Miss Maxwell's name is inscribed more deeply still in the minds and hearts of her nurses."

From the same journal we quote: "There can be no doubt whatever but that Miss Maxwell instituted the standardization of nursing technique and procedure. Other hospitals later developed, amplified and improved upon her methods, but the inauguration of demonstrations of nursing technique and equipment was conceived for the use of her own students by Miss Maxwell, developed by her and finally made public. . . ."

"To Miss Maxwell's grasp of the existing conditions in nursing with their needs and their possibilities, to her faculty for looking forward to future needs and to ultimate eventualities, to her genius for detail, is attributable the demonstration method in nursing procedures, a worthy contribution from a great leader to her growing profession."

"Her name will be cherished as long as even one of her graduates lives, and will be written imperishably in the annals of nursing in America." (*The New York Times*.)

Burial with full military honours took place in the Arlington National Cemetery, Washington.

## Maternal Mortality

A request has been received that *The Canadian Nurse* publish a questionnaire on Maternal Mortality which is being issued by the National Council of Women of Canada. Mrs. Adelaide M. Plumptre, chairman of the Special Committee on Maternal Welfare, National Council of Women, has issued the following note to accompany publication of the questionnaire:

Since the publication of the Report on Maternal Mortality in Canada, prepared by Dr. Helen MacMurchy, much interest has been aroused in the subject; and many organizations have undertaken to study conditions and take action to reduce the death-rate of women in childbirth.

For three years the National Council of Women has appointed a Special Committee to study the best methods of enlisting its local councils and federated associations in productive effort for this purpose.

This Special Committee, having surveyed conditions and the work already undertaken by various organizations, came to the conclusion that its best contributions would be the compilation of a questionnaire which might help and guide the study and action of its local councils and other organizations within their own communities. The object of the questionnaire is not so much to collect statistics for national purposes as to direct the consideration of local organizations to conditions and needs within their own communities; and stimulate them to efforts to ameliorate those which are not found satisfactory.

Where there is a Local Council of Women it has been asked to organize this study, drawing into the survey the local officer of health and all other official and voluntary health agencies. Where there is not a Local Council, the Federated Associations have been asked to initiate action along the same lines, avoiding overlapping by co-operation and discussion with other associations. In some rural communities there may be districts where an individual health worker—such as a public health nurse—might initiate the formation of a committee.

The Special Committee has had the great advantage of including representatives of the nursing profession in its membership, and also of having several opportunities to consult with representatives of the Canadian Medical Association in preparing the questionnaire. The Committee would therefore bespeak the assistance of the nursing profession in the local communities, both by guiding committees of lay people and also, in some localities, by themselves organizing the study where it is not undertaken by an association.

### Suggestions for Study and Work for Maternal Welfare in the Various Communities

This study is intended to be a community-wide activity, organized by a small committee of the..... and enlisting the interest of other organizations.

It will not be effectively carried out unless the co-operation of the Medical Officer of Health and of the medical and nursing professions and the social workers of the community is also secured.

The plans call for an intensive study of the subject between February and May, 1929, and a report to this committee in June, 1929.

The special committee requests that:

1. You will appoint a small, active sub-committee, knowing something of the health organization of your community, to organize the study suggested in the accompanying questionnaire.
2. That you will support the work of your sub-committee and give it adequate opportunities for presenting its work to your Council.
3. That you will organize, either through the sub-committee already suggested or by another sub-committee, a "Festival of Motherhood" in or near the week of "Mothers' Day," when, as one item of the programme, your sub-committee in charge of the study will present its findings and report at a public meeting.
4. That, not later than June 30, 1929, you will forward a report of your study and of your "Festival of Motherhood," to this special committee. All correspondence should be addressed to the Secretary, Maternal Welfare Committee, 410 Sherbourne Street, Toronto 5.

Please acknowledge the receipt of this letter and questionnaire, giving the names of the members of the Sub-Committee appointed.

## QUESTIONNAIRE

### Section A                      Statistics of Births and Deaths

Information concerning a birth or a death is submitted to the Municipal authorities by the physician in charge of the case and by the parents for a birth. Special forms are provided by each Provincial Government. Reports are made by each Province to the Dominion Bureau of Statistics.

Your committee should apply to the Medical Officer of Health for permission to study these records and procure copies of the report forms used by physicians.

Name of Community \_\_\_\_\_ Province \_\_\_\_\_

Population \_\_\_\_\_ Area \_\_\_\_\_

In your own community from July, 1926, to July, 1927

" , 1927, " " , 1928 :

1. How many babies were born alive? \_\_\_\_\_ Stillborn? \_\_\_\_\_
2. How many mothers died in childbirth? \_\_\_\_\_
3. How many mothers died within four weeks of birth of child? \_\_\_\_\_
4. How many of these were resident? \_\_\_\_\_ Non-resident? \_\_\_\_\_
5. How many confinements in home? \_\_\_\_\_ In hospitals? \_\_\_\_\_
6. What was the maternal death rate? \_\_\_\_\_
7. How does your rate compare with that of:
  - (a) The Dominion? \_\_\_\_\_
  - (b) Your Province? \_\_\_\_\_
8. How do you account for any variation recorded in 7 (above)? \_\_\_\_\_

### Section B                      Maternal Care

Maternal Care includes:

- (a) The care of the mother before the birth of the child: ante-natal care;
- (b) The care of the mother during the birth of the child: confinement care;
- (c) The care of the mother after the birth of the child: post-natal care.

#### Explanatory Note    Ante-, Intra- and Post-Natal Care

ANTE-NATAL CARE deals with prevention and treatment. To make it effective the expectant mother should place herself as early as possible under the care of a doctor or a clinic, where she will have a complete history taken and a complete physical examination made.

There she will be advised concerning daily conduct, diet, rest, exercise and dress, and will be instructed to report monthly for observation, as well as to send specimens of urine for examination at such times as the doctor suggests.

She will be further instructed to report such conditions as nausea and vomiting, haemorrhage, headaches, backache, dimness of vision, swelling of hands and feet, urinary disturbances, in order that she may receive appropriate advice concerning these conditions; and she will also be told what to expect when labour commences.

INTRA-NATAL CARE, or confinement care, deals with the conduct of labour itself, during which period the patient should be under observation by an experienced observer until the doctor comes.

POST-NATAL CARE includes medical supervision while the patient is in bed and for a month thereafter, at the end of which time a pelvic examination is made in order to determine that there has been a complete return of the reproductive system to its normal condition.

To secure this care, the community needs:

1. Adequate professional personnel with opportunities to provide ante-natal, confinement and post-natal care.
2. Adequate provision for maternity wards and beds.
3. Social relief when the home resources are not adequate.
4. "Health Sense" in the community at large.



**Section C****1. ADEQUATE PROFESSIONAL PERSONNEL:**

- (a) How many doctors taking confinement cases? .....
- (b) How many graduate nurses: .....
- Private? ..... Visiting? ..... Public Health? .....
- (c) How many non-graduate nurses? .....
- (d) How many midwives? .....
- (e) How many visiting housekeepers or home helpers? .....
- (f) What other help? .....

**2. FACILITIES FOR ANTE-NATAL CARE IN YOUR COMMUNITY.**

"No sound progress can be made in the reduction of maternal mortality apart from ante-natal care" (Sir George Newman, Chief Medical Officer of the Ministry of Health, England).

- (a) What is being done in your community to educate young married women as to the importance of ante-natal care? .....
- (b) Is there a demand for ante-natal care? .....
- (c) Is the demand being met by either private physicians ..... or clinics? .....
- (d) If clinics, state: Number? ..... Average Attendance? .....
- Conducted by? .....
- Remarks .....
- (e) If there are objections and obstacles to ante-natal care, please state them .....

**3. CONFINEMENT CARE IN HOME AND HOSPITAL.****IN HOME**

- (a) How many mothers confined in own homes? .....
- (b) Did they have opportunities for consultation with a physician, instruction from visiting nurses, or home nursing classes previous to confinement? .....
- (c) Is adequate use made of professional personnel as described above? .....
- (d) How many had no nurses? .....
- (e) How many had no doctor? .....
- (f) How many had any opportunity of instruction from physician? .....

**IN HOSPITALS**

- (a) How many public hospitals taking maternity cases? ..... Wards? ..... Beds? .....
- (b) How many private hospitals taking maternity cases? ..... Wards? ..... Beds? .....
- (c) How many days does the patient generally stay in hospital after confinement? .....
- (d) Does your community need more maternity beds? .....
- Please state nature of need and what is being done to meet it. ....
- (e) Is there adequate provision of inexpensive private and semi-private accommodation? .....

**4. POST-NATAL CARE IN YOUR COMMUNITY.**

After childbirth every mother needs, bedside medical and nursing care:

- (a) At least ten days in bed.
- (b) Rest of mind as well as of body. .
- (c) Nourishing food.
- (d) Ante-natal examination at end of six weeks after confinement.

What arrangements has your community for rendering these services? .....

Visiting nurses? ..... How many? .....

How do they charge? .....

Rest Homes? ..... How many beds? ..... How do they charge? .....

Is public opinion informed as to the need of ante-natal, post-natal care? .....

Does the fee for confinement care include ante-natal and post-natal care? .....

If there are objections or difficulties, please state them .....

**Note.**—Sections 5 and 6 are intended only for large centres in which there are organised Social Welfare Agencies.

**5. FINANCIAL CAUSES OF LACK OF CARE.**

- (a) In how many confinement cases was the proper care not received because of financial limitations as distinct from a lack of appreciation of the need of such care? .....

- (b) In how many of these cases would free clinic and hospital care have met the situation?-----
- (c) Having had access to the care mentioned in (b), how many would still have lacked adequate food, rest, etc., both before and after confinement?-----

#### 6. WELFARE WORK IN YOUR COMMUNITY.

- (a) Have you a family welfare organization to deal with those cases mentioned in Section C 5 (c). If so, is it conducted by voluntary workers, or does it employ trained Social Workers, or both?-----
- (b) If you have a family welfare organization, will you confer with its workers in classifying the cases in Section C 5 (c) under the following causes:
1. Lack of intelligent management of resources by mother.
  2. Lack of intelligent management of resources by father.
  3. Lack of sufficient employment
  4. An inclination to avoid employment.
  5. Physical handicap that makes wage inadequate.
  6. Mental handicap that results in inadequate wages.
  7. Illness in the family (other than the mother's).
  8. Other causes.
- (c) Is your welfare work sufficiently adequate that the services of a trained Social Worker are available for the adjusting and building up of each of these problem homes? Of a Volunteer Worker?-----
- (d) Is public opinion sufficiently concerned about the provision of guidance, encouragement, and, if necessary, relief, for these problem homes at ordinary times?-----
- (e) Does public opinion recognize the special need of the services mentioned in (d) for the period before and after confinement?-----

#### 7. ATTITUDE OF THE COMMUNITY TOWARDS MATERNAL CARE.

1. How does your Society co-operate with public health officials, doctors, nurses and social workers to improve conditions?-----
2. What suggestions have you to make regarding the education of the expectant mother?-----
3. What efforts are being made in the community to educate your married people (both husbands and wives) in this matter?-----
4. Do the Service Clubs interest themselves in it?-----
5. What forward movement in Maternal Care is needed in your community?--
6. What plans have been made to support it?-----

### *The Importance of the Social Life of the Student Nurse*

By BEATRICE CREASY, President, Student Government, Training School for Nurses, Winnipeg General Hospital.

There is a tendency for the nurse in training to drop all former activities, acquaintances, and interests to devote all her time and attention to the work in hand, i.e., the routine hospital work and the study required to become a graduate nurse. To my mind this attitude is in some ways laudable, but in the long run most unfortunate, defeating its own purpose, for if anyone ever required a broad and liberal education for success in her work, it is the nurse. Just at this juncture I would like to say, that I feel it unwise for young and inexperienced girls to enter training, because they have not had time to become interested in

various social activities, or to form tastes for the cultural things of life, which, once formed, are more or less permanent interests, but which are not likely to be begun in the busy life of the training school. The importance of a sound preliminary education cannot be over-estimated.

One cannot have too many points of contact. It takes considerable effort but it is indeed worth while to keep in touch with one's old friends, with the various organizations to which one previously belonged, and with social and current events taking place in the world outside the training school, for the training school is a

little world in itself. There is a great danger of becoming so absorbed in the work in hand that one gets into a rut, wearing it deeper and deeper, till the broad horizon is lost to view and life becomes a very narrow and single tracked affair. Often I hear the cry, "O I would love to go, but I am too tired!" True, but even psychologists vouch for the truth of the old adage "A change is as good as a rest," and one often wonders just how much of fatigue is boredom, the result of monotony. Have you ever taken part in some very enjoyable sport when feeling "dog tired" and been much refreshed by it?

Let me tell you of some of the ways in which our training school is trying to solve the problem of broadening the life of the student and making her a more social being.

A splendid training in the development of executive ability is given by the organizations of the school. Each class has its own executive, while at the head of the whole student body is the student Government Council, which serves as a link between the student and the training school office. The council consists of president; first and second vice-presidents, who look after order in the home, and the late leave permits, respectively; the secretary; the treasurer; the social convener; the assistant librarian; and two representatives from each class, namely, the president and the secretary-treasurer.

Our library affords opportunity for keeping in touch with current events and with what is new in our profession. The room itself is so bright and attractive that it is inviting and restful. The library contains not only reference books but the daily newspapers and other current publications, with a growing stock of the good authors. It is presided over by a librarian who is always willing to help the student. The assistant librarian has arranged for a course of extra curricula lectures on various topics by some of our best and most popular public speakers. Some of the topics are "Canadian Authors," "Women and Politics."

There is no need to outline the value of a sports programme. This year we organized under the leadership

of the social convener, who divided the field into the following groups—basketball, badminton, skating, swimming, and out-door, which includes tobogganing, snow shoeing, and hiking. Each student must belong to one group and may belong to more. At the head of each group are three leaders, one from each year, who organize their group and arrange the games, parties and practices. We are fortunate in having a good swimming pool and tennis courts of our own, and access to the gymnasium in the Medical College for badminton and basketball.

The glee club is an active organization meeting once a week for practice. For several years it has taken part in the Manitoba Musical Festival, with no discredit to its conductor or the school. By concerts it has raised sufficient money to equip the home with a baby grand piano and an orthophonic. The glee club gives its members a great deal of pleasure and affords them a chance of learning more about good music and of keeping in touch with the musical world.

The various social functions of the school add greatly to the students' enjoyment. Arranging for these functions, managing them, and acting as hostesses at them, gives the students good experience and develops a certain amount of poise. There are the dances given by the various classes, the class parties, and the school parties, such as the Christmas Tree and the New Year's dinner. This year we have added school teas to the list. Each Wednesday the school and staff are invited, the classes acting as hostesses in turn. Our beautiful reception room is a great asset at all times, making the arrangement of functions easier, and having an excellent floor for dancing. It is also an ideal place to entertain one's visitors.

The nursing profession has had a great many traditions to live up to, and others to live down. Among the latter is the idea that a nurse's life is one of martyrdom, and that in entering training one necessarily gives up all joys except the joy of service. It is my hope, and I believe we are going about it the right way, to prove this old idea false.

## *\*Progress and Opportunities in the Field of Nursing*

Wonderful achievements and steady progress under all kinds of difficulties have marked the course of the nursing profession during the past twenty years. Apart from the medical profession, perhaps, there is no other line of human endeavour that has made such gigantic strides through the same period of time. There have been successes and failures in business, vigorous growth and chilling depression along industrial lines, good times and hard times on the farm; in a word, prosperity and adversity in all walks of life, but through it all, through storm and calm, through sunshine and clouds, the nursing profession has marched on in a direct line of progress. This has not been achieved without struggle and sacrifice, without determination and courage. As we stand today on the threshold of a new era in nursing education, it is well to remember that this remarkable evolution is the sole product of hard work and self-abnegation.

As we look into the future, all things have not been made known to us, yet we can see far enough to discern certain lines of inevitable development. It is generally believed by the best authorities on the subject that we have only commenced to tap the possibilities in this field. The present-day world with all its materialism is changing its attitude towards the work of a nurse. This is verified in various ways, but particularly by the step that universities are taking in their affiliation with hospitals and by the part taken in public health welfare. In this day of reconstruction and organization the whole attitude of nursing and nursing education is very different from the conditions that existed twenty years ago.

The rapid expansion in the field of nursing in late years has created a wide and ever-increasing variety of positions to choose from. Private nursing is undoubtedly the most familiar to the general public. The private duty nurse works by the bedside of the sick either at home or in the hospital, and during that time is responsible for the treatment and general welfare of the patient. In recent years there has been a demand for specialists who are qualified to give expert care in certain classes of diseases, such as mental and nervous cases, maternity work and children's diseases.

The public health nurse is recognized today as a necessary factor in the great warfare for life against disease and death. The various types of health work have made it necessary for nurses to develop special methods and technique for the different phases of this work. We have, for example, the school nurse, who extends general health supervision over the children in public schools. She helps to prevent the spread of infectious diseases, teaches simple rules on personal hygiene, sees that physical defects receive proper attention and serves as an expert adviser in the teaching and maintaining of proper living in the schools. The rural nurse fills various capacities in remote districts where she has often to fill the combined duties of nurse, board of health officer, and social worker, all in one. Then we have the T.B. nurse, whose work is of inestimable value in checking the early course of this ravaging disease. In the large centres there is an ever-growing demand for the child welfare nurse who devotes her time mainly to the prevention of illness among babies and the teaching of mothers. These and many other branches of health work are closely

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(\*An essay by a student nurse, St. Martha's Hospital Training School for Nurses, Antigonish, N.S., read at the graduation exercises, 1926.)



related, and a number of them are sometimes combined under one nurse.

Then we have the great field of hospital work, which is becoming wider every day. There is an ever-increasing demand for superintendents of hospitals, administrators, superintendents of nurses, instructors, floor supervisors, dispensary nurses, dietitians, social service workers, anaesthetists, laboratory technicians, and others.

There has been a recent movement in the United States, which though not yet fully developed, promises to bear abundant fruit, and that is rural extension work. This new activity, which is carried on in connection with universities or agricultural colleges, offers nurses golden opportunities of carrying the gospel of health, hygiene and sanitation to remote districts. Nurses are now engaged in several states to conduct institutes and give lectures throughout the country on health subjects. We do not require a very high degree of farsightedness to see the day when we shall help our country in this practical way.

Again, there are many branches of public welfare work which remain still undeveloped and await investigation and organization. There are many problems that are extremely practical and vital to public welfare still unsolved. The system of nursing education itself is undergoing radical changes and calls for a high type of educated woman. The solution of any of these problems offers scope and opportunities to nurses of intellectual and administrative ability. There is a special call for leaders who in addition to their professional training have the capacity for enthusiastic, whole-hearted, constructive effort. Experience shows

that wherever women have shown their fitness for superior service in the nursing field, they have been duly recognized. The opportunities for real service are positively unlimited.

The nursing profession compares favourably with other occupations for women, inasmuch as the nurse is engaged continually in real live problems, and thus not merely in abstract preparation. The main object of her work is to bring a fuller, happier and more useful life to all, through the active promotion of health and proper living. Lady Helen Munroe Ferguson in her address on "The Nurse as a Citizen," congratulates them on the fact that their horizon instead of being narrowed becomes continually wider, and their work, instead of tending to contraction of character and impoverishment of soul, tends to bring out and expand every quality with which they are endowed. Another author would have the nurse the foster-mother of the race, when he says: "Whenever and wherever there is life to be tended, nourished or nursed, whether the life be yet unborn, or new-born, or senile, or ill, there is the field for womanhood exercising its great function of foster motherhood."

It is, therefore, quite evident and safe to conclude that the graduates of 1928 are entering upon a field where there are uncounted opportunities of service and where the possibilities of self-development and social usefulness are limited only by one's own capacity. However, it must be borne in mind that these same opportunities and possibilities are not productive of any good unless they are met with individual and conscientious application as well as earnest and constructive effort. It is for us to "bear the torch and pass it on."

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## *Miss Annie J. Hartley*

Miss Annie J. Hartley, graduate of the Toronto General Hospital, has recently been appointed Matron-in-Chief under the Department of Pensions and National Health for Canada.

She was born in Brantford and for several years after her graduation was

the Royal Red Cross (1st class) in 1916, and mentioned in despatches by General Milne in 1916, and awarded a bar to the Royal Red Cross in 1918.

She returned to Canada for demobilization in July, 1919, and after a short holiday at home was made matron of the D.S.C.R. hospital at Burlington, Ontario, from October, 1919, to 1920, when she became Matron to Christie Street Hospital, Toronto.

In this newly-created position, Miss Hartley becomes Matron-in-Chief of all hospitals of Pensions and National Health in conjunction with her duties as Matron of Christie Street Hospital, with headquarters there. Her new duties will include occasional visits of inspection of these hospitals, situated at various points throughout Canada.

The Alumnae Association of the Toronto General Hospital, overseas nurses and her many friends in the nursing profession, as well as the great number of patients who have known her kindly interest wish Miss Hartley much enjoyment in her enlarged field of usefulness, and are very pleased regarding the honour which has been bestowed upon her.



MISS ANNIE J. HARTLEY

night supervisor in the Toronto General Hospital before going overseas as Matron of No. 4 Canadian General Hospital, in May, 1915.

Miss Hartley has a distinguished war record of military service, in Quebec, Canada; Shorncliffe and Basinstoke, England; Etaples, France; hospital ship duty from Malta to Gallipoli; and two years' service in Salonica, Greece. She was awarded

### "THE LADY WITH A LAMP"

During the early part of January a play entitled, "The Lady with a Lamp," by Mr. Reginald Berkeley, was presented at the Arts Theatre Club of London, England. In referring to this play, "The Nursing Times" reports, "Beautifully written, exquisitely staged, and acted with a restraint which gave to the production that dignity which the subject merited. The play opens at Florence Nightingale's home in Hampshire." This journal states that while the first act is somewhat disappointing, the remaining acts, "are a skillful presentation of her as a woman with a clear brain as well as vision, rather than as a perpetual smoother of pillows. It comes as a genuine inspiration not only to nurses but to every woman who feels that somewhere in the world there is work for her to do."

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

### *\* Among the French Canadians in the Province of Quebec*

The history of the nursing profession in our country goes back to the year 1639, when the land was under French domination. During this period the ladies of the court of Louis XIII were greatly interested in social work. Thanks to the publication of the "Relations" of the Jesuits, they knew of the pressing needs of the colony which was still in its infancy. The Duchess of Aiguillon, niece of Cardinal Richelieu, whose zeal equalled her piety, resolved to furnish the necessary funds to build in the city of Quebec a hospital destined for the colonists and the Indians.

Three nursing sisters of Dieppe, of the order of the Chanoinesses of St. Augustine, were chosen for this heroic enterprise. In company with the first group of Ursuline nuns (among whom was Mother Marie of the Incarnation, called the Therese of New France) they arrived at Quebec on the first day of August, after a terrible three months' voyage. Just then an epidemic or small-pox broke out among the Hurons. The nursing sisters, who were given temporary lodging by the Jesuits, set to work immediately and in less than three months our heroines had given care to more than two hundred of these unfortunates, whose filth was equalled only by their misery.

A life of incredible suffering and privation began for the group of noble women and lasted for them and their successors for more than a century. Their unconquerable courage and their great charity were above all praise; extreme poverty, the cruelty of the Iroquois, fire, war, nothing could make them give up their work, nothing could conquer their devotion to duty.

For more than three hundred years the nursing sisters of the Precious Blood in Quebec have lavished their charity and ability on thousands of the sick in their district, where they are regarded with gratitude and veneration.

They have had many trials in the course of these three centuries. To-day they have numerous flourishing hospitals, where the sisters give themselves to their work without stint, following in the footsteps of their holy predecessors, the first heroines of French Canada.

Some years after the arrival of the nursing nuns in Quebec, in 1642, Ville-Marie, now Montreal, was founded 180 miles from Quebec. The distance of the borough of Hochelaga (the Indian name for Montreal) from that of Stadacona (the Indian name for Quebec) necessitated the establishment of a new hospital, that of the Hotel-Dieu of Montreal. The sublime devotion, the heroic sacrifices of Quebec were repeated at Ville-Marie.

To the great Jeanne Mance (the collaborator of Maisonneuve) whose ability and qualities we know, was entrusted the direction of the new hospital. It has well been said that Jeanne Mance is the first woman who appears in the history of Ville-Marie (Montreal). With her noble heart, her sound judgment, her enterprising spirit, her firm will, and her heroic virtues, she is the fine type on which her followers are modelled. She had the nursing sisters of le Fleche associated with her to help and continue her work.

The history of these ancient institutions is the history of Montreal, of its heroic origin, of its stirring struggles, of its astonishing progress.

\*Published by courtesy of The I.C.N.

Since that remote period the number of our institutions has increased considerably. We have today in the Province of Quebec fourteen hospitals whose schools of nursing are approved by the Association of Registered Nurses of the Province of Quebec, without counting a good number of others, especially in the district of Quebec, which have not yet judged it opportune to have their schools approved and their graduates registered.

The Association of Registered Nurses of the Province of Quebec dates from 1920, when it was legally approved and granted a Charter by the Legislature. In 1925 the Association was authorised to make membership conditional upon the passing of an examination. This examination is held twice a year under the direction of the Committee of Management of the Association for the graduates of all the approved schools. The law provides for an exception in the case of the graduates of the schools affiliated with any of the French-Canadian Universities of the Province, for whom the Board of Examiners is composed of members of the University and of members of the Association.

It being our intention to give here only a general idea of the status of nursing in the Province of Quebec, we shall limit our review to the principal schools of nursing among the French Canadians.

The first was founded at the Hospital Notre-Dame in the month of October, 1899. The hospital itself was established by the initiative of Dr. P. Lachapelle, the Reverend Father Rousselot, P.S., and the Mother Superior General of the Gray Nuns, Mother Deschamps. "We see here united in a common undertaking to establish a national and catholic enterprise, the University, the order of Saint-Sulpice and the Gray Nuns. It is on this triple foundation that the Institution rests with us and has its reason for existence—and it should realise in a form of charity unknown up to this period an intimate religious and secular collaboration."

The school of nursing was founded with the object of charitable work and for clinical teaching; in its development it had necessarily to extend its benevolent action to young women wishing to learn the art of nursing.

This school, as well as the Hospital of Notre Dame itself, is under the direction of the Gray Nuns. These worthy daughters of the venerable Mother d'Youville lead a quiet existence, but none the less they have a remarkable spirit of progress and their devotion to duty is so familiar to us that it passes almost unnoticed.

The second French-Canadian school of nursing in Montreal was founded at the Hotel-Dieu Hospital in 1901, and received its legal recognition in 1920. Its affiliation to the Association and to the University of Montreal gave it the final official approval.

In 1907 the third school of nursing was opened, that of the hospital of Saint-Justine. "It was"—so says the chronicle—"on a November day, when the leaves were falling from the branches like wounded birds, that some ladies met together in an old house. They had \$87.11 in money, a box for a table and four chairs, with which to lay the foundations of the Saint-Justine Hospital for Children. These early workers had a heavy task to accomplish. To undertake the organization of a hospital for children at this period was to fight against fixed prejudices. It was considered that children ought to be cared for in their families, or, if necessary, in the existing hospitals with the adults. Yet, because it was necessary to fight against these prejudices and because there were little ones who wept for help, a week later a bed, a ton of coal, a sick child and a nurse entered the old house simultaneously. The Saint-Justine Hospital was founded."

To these women, directed by Madame L. de G. Beaubien, the population of Montreal owes a debt of gratitude it can never discharge.

The medical department of the Saint-Justine Hospital, under the di-



rection of Dr. Raoul Masson, was organised in January, 1908, and the dispensary was opened in March of the same year. Already many mothers were coming to the consultations with their children in their arms.

In March, 1910, the "Filles de la Sagesse" arrived from France to co-operate in the fine work of Saint-Justine. The hospital today has 300 beds for children, excellent dispensaries, a maternity department and a school for crippled children.

From Montreal, let us go to the city of Three Rivers, 96 miles lower down on the north shore of the great Saint Lawrence River where we find the fourth school of nursing. This is annexed to the St. Joseph Hospital, under the direction of the Sisters of Providence, a community founded in Montreal in 1843 by the great Bishop Bourget and Madame Gamelin. The community was modelled on that of the Sisters of Charity of Saint-Vincent-de-Paul, and was founded for the relief of all sorts of human misery; of the sick of every category; of foundlings, old people, orphans, deaf and dumb, incurables, and of the mental cases found in the 102 establishments of the Sisters of Providence scattered throughout all North America—to give the care necessary for their cure, or a refuge, protection and a home.

The school of nursing of the Hospital of St. Joseph, at Three Rivers, is affiliated to the University of Laval, in Quebec, and approved by the Association.

In October, 1912, another school of nursing (the sixth) opened its doors. This was the school of the Hospital of Saint-Jean-de-Dieu, an establishment under the direction of the Sisters of Providence. More than 3,500 mental cases are received in this institution. Of this number more than 600 are under treatment in the various medical and surgical departments for physical disease. The pupils of the school receive a complete training, comprising the two months affiliation they have at the Saint-Paul Hospital for con-

tagious diseases and at the Hospital de la Misericorde for maternity training. The school is approved by the Association and affiliated to the University of Montreal. It is well organized, and contains the most modern material for the education of its pupils. Both directresses and pupils are entirely devoted to the best interests of the profession.

For the history of the fifth school we must return to Montreal, to the Hospital de la Misericorde, an Institution founded in 1846 by Monseigneur Ignace Bourget, Bishop of Montreal and Madame Jette, known in religion as Mother Marie de la Nativite. At first the hospital had no school, so Madame Perras, a charitable widow, offered her services to the institution, which accepted them with gratitude. Several hospitals sent their pupils there in order that they could obtain the training that they needed in obstetrics, and in this way the teaching of pupil nurses began. Gradually the institution agreed to receive pupils desiring to specialize in obstetrics, and the school was established. As this hospital now offers general training its school was approved by the Association in 1925 and affiliated to the University. The Hospital General de la Misericorde also bears the title of "The Catholic Maternity Hospital of Montreal."

The seventh school of nursing is in the city of Three Rivers, at the Normand and Cross Hospital. The hospital was opened in 1912 and the school was founded at the same time. It is approved by the Association and the University of Laval, in Quebec.

In the city of Sherbrooke, situated in the Eastern Townships, we find the eighth school of nursing, in the Saint Vincent-de-Paul General Hospital, directed by the Sisters of Charity of Saint Hyacinthe. Instruction for nurses was started in 1913. Like the preceding schools, it is approved by the Association and the University. The city of Sherbrooke rightly feels itself honoured in the possession of a hospital which, although distant from

the centres of university teaching, offers to its pupils every facility for a complete training.

Lachine, in the suburbs of Montreal, gives us the ninth school of nursing, which is that of the St. Joseph Hospital, directed by the Sisters of Providence of Montreal. This little hospital has already received under its hospitable roof hundreds of sick who have there again found health and happiness. The attractive maternity department allows the pupils to obtain their training in obstetrics without having to go elsewhere for it, which is an advantage greatly appreciated.

This short resume of the history of our principal French Canadian schools of nursing will give, we hope, to our foreign colleagues an idea of the status of nursing in the Province of Quebec, among the French Canadians. In all these schools the programme of study is that prepared and required by the Committee of Management of the Association of Registered Nurses of the Province of Quebec.

This programme comprises three years of study and some months of affiliation in general or special hospitals (according to conditions) so as to complete the training of the students.

The greater number of the French-Canadian hospitals are directed by the nuns of various communities and have their own schools, as a result of which graduate lay nurses find only rare positions in these hospitals. Up to 1925 private duty was almost the only field open to the latter.

However, in 1925, the University of Montreal with the help of the Provincial Government, that of the Health Department of the City of Montreal, of the Anti-Tuberculosis and General Health League of Montreal, and also of the Metropolitan Life Insurance Company, founded its School of Public Health Nursing.

This school gives a post-graduate course of nine months to graduate nurses from the schools of nursing approved by the Association and affiliated to the University of Montreal. It has as its object the training of

public health nurses, the need for whom is greatly felt in the Province.

Those in charge note with satisfaction the good already accomplished in the district where the school's health centre is situated. The graduates usually obtain important positions. The number of students is increasing each year to such an extent that it has been necessary to limit the number of admissions.

In the Province of Quebec special problems arise, similar to those met with in Belgium on account of the fact that there are two races, speaking two different languages. But it is to the honour of the Association that it has been able to unite in its membership nurses of these two races. Its Administrative Council is composed of members of the two groups, who understand each other very well and whose relations are most friendly.

The distinguished visitors who will do us the honour of attending the Congress of the International Council of Nurses in 1929, will be able to see for themselves how much the French-Canadian nurses are interested in their profession, how much they desire its progress and its improvement from the ethical point of view as well as from the technical and the patriotic.

We extend to our honoured guests the most cordial welcome, and we hope that they will have only pleasant memories of their sojourn with us to carry back to their own countries.

Signed: Reverend SISTER AUGUSTINE, F.C.S.P., Superintendent of Nurses St. Jean-de-Dieu Hospital and Chairman of the French Section of Nursing Education of the Association of Registered Nurses of the Province of Quebec.

Signed: EDITH B. HURLEY, B.A., M.A., R.N., Director of the School of Public Health Nursing of the University of Montreal and Professor of Public Health Nursing at the University. Vice-President, Association of Registered Nurses of Province of Quebec.

Signed: (Mme.) RACHEL BOURQUE, R.N., 1st Assistant School of Public Health Nursing, University of Montreal; Member, Board of Examiners, Association of Registered Nurses of the Province of Quebec.

## Vocational Guidance

By GRACE M. FAIRLEY, Victoria Hospital, London, Canada.

Recently there appeared in "The Canadian Red Cross Junior" a series of articles entitled, "Do you want to be a ———?" This last month the article was, "Do you want to be a Nurse?" This article outlined in a very interesting way the outstanding points in the profession that are likely to appeal to a young girl who is contemplating a professional career.

Wisely, it stressed the importance of a sound educational background, did not make the picture too attractive, but emphasized the idea of service which is so necessary in the mental makeup of the prospective nurse.

In Canada, at the present time, there is no shortage of applicants to the schools of nursing offering a well balanced course, but there is a great need of some earlier contact with prospective students with a view of giving some advice or guidance along educational lines, so that the embryo nurse will have the best type of preparation for what is becoming an increasingly heavy course.

The various departments of education have done much in the last few years in developing this attitude of professional and vocational guidance, but it has not gone nearly far enough.

There is not a superintendent of nurses, or principal of a school of nursing that will not acknowledge the frequent applications of young women evidently quite serious in their desire for training, but who will, without a thought, expect to take up the reins of the nursing course after a term of anything from one to three years away from school, and in the meantime having made no effort at any systematic study.

After reading this article in "The Canadian Red Cross Junior," the writer was again impressed with the value of educating public opinion—through the medium of the press; and if the various provincial nursing organizations could have articles, similar to the one referred to, published in the city and county newspapers, from time to time, probably under the "Women's Page," a great benefit would be derived both by students and schools.

In each locality where there is a hospital, it would be of great advantage if an annual contact could be made with the high school students through the co-operation of the principals—not so much with the view of tempting students to take up nursing, but rather of discouraging those who have not an adequate education and at the same time, urging the sincere student to continue her studies to the limit in preparation of the profession.

There is nothing sadder than to see the good all-round nurse handicapped by lack of preliminary education from accepting or being accepted for some post that she might otherwise have filled with ability and distinction, and too often this is the result of lack of knowledge of the needs, or to use today's phrase "Vocational Guidance."

EDITOR'S NOTE.—The circulation of "The Canadian Red Cross Junior" has now reached 30,000 copies an issue. This satisfactory condition has been reached through the united effort of the circulation managers in all the provinces under the leadership of Miss Jean E. Browne, Director of The Junior Red Cross in Canada, and the Directors of the provincial branches.

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## INTERNATIONAL COUNCIL OF NURSES

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**Applications for Exhibits Space** and the amount required, to be forwarded to Miss C. M. Ferguson, Royal Victoria Hospital, Montreal, before April 1st, 1929.

## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
Miss THERESA O'ROURKE, 733 Arlington St., Winnipeg, Man.

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### *Hourly Nursing*

By MARGARET L. MOAG, Superintendent, Victorian Order of Nurses, Montreal

This is a subject of vital interest at present to the nursing profession, to the medical profession and to the laity at large. Articles are appearing periodically in our own professional magazines, social welfare magazines, and during the last two years many others have had excellent write-ups on this question. There are many reasons why it has become so important.

There have been many changes during the last twenty-five years. Many of us who have been actually engaged in our profession for a long period of time can speak with experience of these numerous changes. We all know that patients do not remain in hospitals for as long a period of time as formerly. They are now sent home to convalesce, as hospital beds are very valuable today on account of the shortage. Much more emphasis is laid on the prevention of disease than formerly, people seek advice and treatment before disease has made headway, previously they waited until acutely ill so the very character of illness seems to have changed. Someone says the high cost of living has made life a struggle for most people. People of moderate means live in the small apartment, domestic service has become so difficult to obtain that people have been forced to do without. Even the type of nursing seems to have undergone a steady change. Families are not satisfied with the nurse who has not a broad outlook on her community, and they expect her to know something of the health resources in that community and how to teach and instruct while in the home.

Private duty nursing is serving thousands of people annually but it

no longer fits all types of cases. We all recognize the fact that there are many families who are and always will be financially able to engage the service of the private duty nurse for any length of time and pay her her maximum fee. We also know that the poorer families receive necessary care at a very small fee, or free if unable to pay anything, from an organization like the Victorian Order of Nurses, financed by community funds. But what of the families that lie between these two groups, those who cannot make any provision in a family budget for illness that does come in spite of all they may be trying to do to prevent it? Today there is a great respect for ability and knowledge, and the statement has been made that it is not fair that a few people can absorb the full time of highly trained capable nurses when the full time is not essentially valuable to the patient. Doctors, lawyers, engineers, etc., do not give more than an hour a day to their clients or patients, and people are learning now that the time of the graduate nurse also is very valuable.

In a recent magazine there was an article on, "Nursing the family of moderate means." It described the long street in a certain city where Mrs. Van Swagger in her luxurious home at the top of that street was ill—three nurses were in attendance. At the end of the street in a small home was Mrs. Brown, ill too, with the visiting nurse coming twice a day and her sister carrying on between her visits. In an apartment house halfway between, the bank clerk was ill with bronchitis, and his young wife, who had spent her entire youth at a typewriter, was trying to care for



him and weeping because she didn't know how. There was a wee babe in another apartment—a premature, just home from the hospital, the young mother not strong enough to give him adequate care, and in another apartment house an old couple lived—the old gentleman, a retired college professor, needing more care and treatment than his wife could give. Their doctors had all said they should have a graduate nurse's care, all felt they didn't need and could not afford full-time nurses, but they did not know the visiting nurse would care to come, or had time to come to them, as they felt her first consideration were the very poor.

Within a stone's throw of those people were two private duty nurses who dare not go out because they were on Registry call and needed work so badly. One spent the afternoon shampooing her hair, the other cleaned up the apartment: both jumped every time the phone rang.

Of course any one of these families in the middle of the street would go to a hospital if their illness was severe, and if it were a matter of life and death they would engage the private duty nurse on a twelve or twenty-four hours basis, even though the cost were entirely out of proportion to their incomes. These families needed the care and advice which only a well-trained nurse can give, and the nurses waiting for calls were paying for their long days of waiting.

Something must be wrong with a system that allows wantage of skilled nursing, when nursing is to be done, among a large group of people who require the service of a nurse for a short term, every day at least. There are many people of refinement and education living in our towns and cities throughout Canada who cannot afford a full-time nurse for minor illnesses where it is not necessary to have a private duty nurse remain all day, and no effort has been made to meet this need by the professional body of nurses. Special treatment at regular hours, dressings, general care

morning and afternoon (particularly do families demand someone to make the patient comfortable at night), instruction for the mother when she comes home from the hospital with her new babe: many families will pay anything to have that daily visit at a regular time for a week or ten days and in these cases they frequently want daily formulae prepared for twenty-four hours. Communicable disease cases could also come under this type of service, also relief for special nurses. These are only a few of the many demanding instances at present, and in very obvious need of the type of service which hourly nursing can give.

May I quote from Miss Smellie's recent article—"It was stated recently that the cost of living is still far from the pre-war level. Moreover, salaries of teachers, clergymen and clerks have not been advanced, either in proportion to the present day financial requirements of their places in society or in some instances even to the needs of a more respectable existence. A statement was made (at the American Hospital Association in 1926) that those who are neither rich nor poor comprise four-fifths of the country's (United States) population. This means that when eighty out of one hundred people become ill, they are more or less embarrassed in providing for themselves so-called private room service with the additional expense of physicians' and nurses' fees. It is, therefore, high time to turn attention to the needs of the large number of people of moderate means who appear to have been somewhat neglected. It has been estimated that 1% of the population need visiting nursing care for illness each and every day; of course they do not all get it. Dread of illness and what it may involve drives the individual to work longer than he should when ill, and to return to work long before he is well and strong again."

What is hourly nursing? It is service provided and paid for on a time basis, the charge being so much per hour or part of an hour, and is

quite different from service provided and charged for on a visit basis.

In the United States it is claimed that hourly nursing was first started in California twenty-five years ago by a nurse who felt she wanted more diversion than private duty afforded her. She advertised her venture and soon worked up a practice. The idea quickly spread to other places and other nurses began the same line of work.

In 1927 a survey was conducted by Miss L. M. Tattersall, statistician of the National Organisation of Public Health Nursing, to determine the amount of hourly nursing carried on by the Visiting Nurse Association group in the United States. It was found that in forty-six organizations upon which the report was based, hourly nursing was being conducted by Visiting Nurse Association groups in forty-five cities. In the study of work of registries, now being made by the American Nurses Association, reports received in 1927 show that hourly nursing is carried as part of the regular service by thirty-eight of fifty registries.

Hourly nursing is really a development of visiting service such as is being given throughout Canada wherever the Victorian Order of Nurses exists, for while the service exists primarily for the poorer families, independence has always been encouraged by requesting a fee for services rendered, and those who are financially able have always paid the cost of the visit.

In Canada the demand for hourly nursing is increasing in every town and city where the Victorian Order of Nurses is established. In the western districts people are requesting the service, and in one city this type of service has doubled during its first year.

There are many families where some one member is willing and eager to take care of the sick one if she had a little teaching, and here at every visit is demonstrated the care and comfort of the patient. There are many cases where two visits a day are all that are necessary: think of

the comfort and freedom from worry it gives these people. The sick one is given first consideration, the nurse calls and does what is necessary and goes to her next case.

An interesting aspect of the possibility of hourly nursing service is that the position of members of the household is not altered by the arrival of the nurse. A wife can still get her sick husband a glass of water, smooth his pillows and prepare an attractive tray. A mother can still minister to her daughter's needs or that of her young baby, and the nurse will be paid only for the skilled service she gives, which only she with her years of specialized training can give adequately, and go on from one patient to another, practising her profession every hour of the day.

**HOURLY NURSING IN OTHER CITIES:**  
In a recent letter from Mrs. Hansen, director of Visiting Nurse Association in Buffalo, New York, she states; "There is only one staff of nurses doing hourly nursing and they are under the supervision of the Visiting Nurse Association. The last call can be made for 9.30 p.m. The nurses in the hourly division of the Visiting Nurse Association have had previous training on our staff as general staff nurses. We have found that a nurse taken directly from the private duty field to do hourly nursing is not as satisfactory as the nurse trained on the staff. All hourly nursing visits are paid for on an hourly basis, and not on a visit basis. When our main office closes at 5 p.m. all calls are taken care of by the Nurses' Official Registry of Buffalo, and all calls at anytime for hourly nursing are referred to the Visiting Nurse Association."

In Cleveland, the Visiting Nurse Association, like the Victorian Order of Nurses, has been doing limited hourly nursing since 1919, but last year they started a special time service with rates of \$2.25 for first hour and a fractional basis of \$1.00 for second hour: this service is only a day service from 8.30 a.m. to 5 p.m. Some working arrangement

with the Nurses' Registry by which the service could be a twenty-four hour one is being considered.

**PHILADELPHIA'S EXPERIENCE:** "The Visiting Nurse Association in this city has been trying out hourly nursing since 1919. Calls are chiefly for the care of chronics, special treatments such as colonic irrigations, enemas, minor operations, relief for private duty nurses with acutely ill patients, moderately ill cases of grippe, tonsillitis, occasionally maternity cases, and some care and instruction in the care of babies and preparation of food formulae after the mother has returned from the hospital. In a few cases patients referred by the staff nurses have received special teaching in Occupational Therapy at hourly rates, but only when the patient is having general nursing care. Calls are answered by the regular staff who have passed their probationary term of two months on staff. Calls are answered within city limits between 8.30 a.m. and 8.30 p.m. Charge is \$1.50 for first hour or fraction thereof; 40c for every thirty minutes after the first hour. After 5 p.m. the charge is \$2.00 for first hour and 60c for each twenty minutes thereafter. Taxi, if needed, is paid for by patient. The majority of cases do not require more than two hours care."

In Philadelphia, hourly nursing "is now regarded as an essential rounding out of the community health programme which deals with human needs rather than economics. Incidentally such a service does much for the nurse in maintaining a balanced point of view of her work. The big problem is not the administration of the service, nor the misuse of the nurse's time, but that of not being able to promise the same nurse to each patient each time. This problem, of course, exists in all nursing to a greater or less degree. Even with this adjustment to face the hourly patient is the benefice of three advantages:

(1) Professional standards vouched for, not only by the state, but by a board of responsible citizens, represent-

ing the medical, nursing and non-professional groups.

"(2) Supervision of nurses' professional work which includes the best and most recent concurrent education in the field of public health and nursing technique.

"(3) Resourcefulness in bringing a trained adaptability and capacity for quick and efficient adjustment to varying conditions. The public health nurse knows how 'to make the best of it.'"

**THE FUTURE:** At present there is no doubt in the minds of the laity, the medical profession, and the nursing profession that the need is very evident. Is it not our responsibility as nurses to provide, so far as in our power, satisfactory nursing care; and if we fail in our duty are we not liable to be censured as a group, because we are not meeting the nursing needs of our people? As to who will ultimately do hourly nursing, this question cannot be settled by a definite statement, beyond the fact that it has already been carried on in a limited way in Canada by the Victorian Order of Nurses. We feel safe in saying that nursing on an hourly basis will do more than any other method for giving scientific nursing care to those who need it and it will quiet the unrest and dissatisfaction so apparent among nurses and lay people.

**DIFFICULTIES:** No one can estimate the many problems and difficulties that may have to be faced by those who undertake to supply hourly nursing, but as the service becomes available many adjustments will have to be made, and much publicity given both to the laity and the medical profession.

"In a visiting nurses organization we have: organization with governing bands of lay people, trained to think in community needs and determine policies based on those needs; a system of receiving and answering calls on a visit basis, nurses covering the entire community so that travel is reduced to a minimum; nurses who are accustomed to making quick

adjustments in all types of homes, thus conserving time which will be an all considerate factor in the minds of the patients' family; nursing supervision thus insuring uniform procedure to the patient when same nurse cannot always attend the case."

We have a method of analyzing our cost per visit, and this is important because the fee for hourly service will be based on the actual cost to the organization and will automatically answer any criticism by public as to over-payment.

We have a system of taking histories, keeping records, and analyzing statistics so that any development or changes to be made may be based on authentic facts.

As for the nurses, there are many advantages in being members of an Association like ours. Standards of work are uniform, policies and ideals are in the best interest of all concerned in the community, the nurse is on regular salary, has regular hours on duty, is given a yearly vacation with salary, sick leave when necessary with pay, she has opportunity for promotion, and through supervision is kept in touch with all the developments in the field of health. Every visit is an interesting demonstration in nursing care and her opportunity to teach health education is unlimited.

Dr. C. E. Winslow, Eminent Fellow A.P.H.A., who is a member of the Committee on the Grading of Nursing Schools, speaking for himself on this subject of hourly nursing, states in "The Public Health Nurse": "I believe that the public health nursing organization is the agent for this work, and that if the public health organizations do not rise to the opportunity, the whole cause will suffer immeasurably. If the organization of private duty nursing is to be effective it must be carried out first of all, with the interest of the public as a whole primarily in view, and secondly, it must be carried out with reference to the highest standards of professional performance. The public health nursing organizations are public service corporations in the highest sense of the

term, and they are the only organizations which have the supervisory force to make a community nursing service work, and work with success. If the registries were to undertake the task they would be forced to build up a duplicate supervision staff, which would be wasteful and almost impossible in view of the limited supply of qualified persons; and if they did, by a miracle, succeed, the result would be to create parallel community nursing services, one for the rich and one for the poor, an outcome which would set our whole movement back ten years or more. What I hope may happen is that by the development of hourly nursing, through the regular visiting nurse staff, by co-operation with the registry and perhaps by the organization of a sort of reserve corps of nurses available for eight or twelve or twenty-four hour service—whether on a salary basis or not, I do not know, but all under sufficient supervision to guarantee adequate standards of service—by some such means as this, I hope to see nursing service in the homes of rich and poor, whether on a visitor, or an hourly, or on a daily basis, developed into one co-ordinated scheme of effective community service. It is no easy task, perhaps it is an impossible task. I cannot but feel, however, that the problem is more likely to be solved by the visiting nurse associations with their prestige and their command of so much of the organizing ability of nurses and of lay directors than by new organizations which might conceivably be developed for the purpose."

As previously stated, there will be many adjustments, but public health organizations are always making adjustments to meet changing conditions. But we must see that our underlying principle must suffer no change, that is, the spirit of service for all people in our communities, irrespective of method of payment; nursing care of the sick in their homes, teaching the prevention of disease and the promotion of health throughout the community.



## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *Fighting Diphtheria in New Brunswick*

By HUILOTA DYKEMAN, Director Public Health Nursing Service.

Like Mr. Barnum of circus fame we in the Public Health field must never let an opportunity to "seize the public at the psychological moment" slip by. This time the opportunity presented itself in the form of a few cases of diphtheria in two adjoining towns of about 6,000 population all told.

Many parents had, of course, heard of diphtheria prevention, and some had even gone to the "extremity" of having their children immunized, but not the majority—It was a case of "why worry?" The time came when a great many did a lot of worrying as they found that it took many weeks to produce a lasting immunity, and that the children might have been protected long before diphtheria appeared in the town. The District Medical Health Officer here stepped in and saved many parents the trouble of pondering further what should be done.

First, a meeting of the School Trustees was held at which the Medical Health Officer explained his method of campaign for having all the school children inoculated with toxoid. It met with the unanimous support of the Board. A general meeting of the town people was then called, notices of which, with articles on "diphtheria prevention" appeared in the press. The clergy were circularized, and notices of the meeting and its purpose were announced from the pulpits. This resulted in a very representative gathering of citizens at which the Health Officer explained the value of diphtheria immunization, the actual procedure, and the proposed plan for having all the children inoculated at one time. The people were eager to co-operate, and the only difference of opinion arose over

the advisability of closing the schools to prevent further increase of diphtheria cases. Timely explanation by the Health Officer of the more modern and successful method of keeping schools open in order that the public health nurse might keep in touch with the children who would otherwise be running loose, satisfied the people.

The School Board then declared that the following Friday afternoon the usual school work would be dispensed with and the time given up to the inoculation of the children. Each child was given a circular letter, sent out by the School Board, briefly explaining to the parents the use of "Toxoid" and the necessity for the three inoculations at stated intervals. The letter also suggested that they bring the pre-school age children to the schools on the day of the clinic for inoculation. On the bottom of the letter was the "consent slip" to be signed by the parent or guardian. These were returned to the teachers, who in a few days knew exactly how many children were to be permitted to take the inoculation. Those whose parents were doubtful or not yet convinced were then visited by the Public Health Nurse and eventually the consents reached 100 per cent.

The clinics were held in three schools at the same time, and local medical help was arranged for by the School Board which employed four doctors at a flat rate for the first and succeeding two clinics. The Provincial Department of Health contributed the services of the District Medical Health Officer, the District Medical School Inspector, and one Public Health Nurse. The local public health nurse secured volunteer nurse helpers for the afternoon of each

clinic. Over 1,000 children, including many infants and those of pre-school age were inoculated in less than two hours on each of the three afternoons.

The outstanding points that made possible the immunization of practically 100 per cent of the child population of the two towns were:

1. A District Medical Health Officer who was a good organizer

and seized a pertinent opportunity.

2. A School Board progressive and open to conviction.

3. A local Public Health Nurse in whom the people had absolute confidence, and whose management of the details of the clinic was without flaw.

4. The whole hearted co-operation of the school teachers.

## *A Health Exhibition in Australia*

By ELINOR N. WADE, Newington, New South Wales

During November 1928, I went, one afternoon, to a Health Exhibition held in the Sydney Town Hall. This Exhibition was organized by the committee that worked during Health Week. To me, it seemed to partake of the usual things one sees at Health Conferences and of the best part of a regular Trades Exhibition.

One section was devoted to the State Board of Health, where one found huge modelled maps in relief showing various water and drainage systems, septic tanks, incinerators and other things pertaining to sanitary engineering.

The departments of agriculture, horticulture, veterinary, poultry and dairy, had some interesting exhibits which drew various groups of people.

The hospital and university had exhibitions of radium cure for cancer and the latest cures and preventive measures for tuberculosis and other diseases.

The Tresillian Mother Craft Association had two model clinics: a Baby Health Centre for the cure of the baby and an Ante-Natal Clinic for the care of the mother, where one could see the nurse engaged in making urinal ses.

In a side-hall one could witness various Health Movies, while on the stage at certain hours there were demonstrations by Boy Scouts, school children, Y.W.C.A. gymnasts, and other organizations of Eurythmics, folk dancing, drills and ju-jitsu; all of which we were informed were for the promotion of our well-being.

Most of the welfare and social organizations had stalls there. One could learn all the mysteries of eugenics or of life saving at sea by talking to the person in charge at certain stalls.

A large part of the hall was taken up by purely commercial stalls, but all more or less of a character that sold goods for the preservation or promotion of health. I tasted samples of many kinds of foods that were guaranteed to fatten me, to give me the necessary vitamins, to prevent constipation, etc. I was really surprised to find a stall there extolling the virtues of a mercolized wax for the complexion. Being a hardworking bed-side nurse, I appreciated the display of sensible and smart-looking shoes, and the lecturette on the prevention of foot trouble at another stall.

The admission to the Health Exhibition was a shilling (25 cents) a day, and it was on for five days. I heard that all mothers who took their children to the Health Centres obtained free tickets. Nevertheless I saw a great many people pay their shilling to enter, which I felt was a good sign, perhaps proving the proverb that one only "got nothing for nothing."

I am sure the whole Exhibition was a success both from a financial and educational point of view. The slogan which was displayed on the catalogues and elsewhere was, "Learn to Live Long and Well." This slogan was the central idea of every display and exhibit, and well worth paying for.

## Book Reviews

**The Soul of the Hospital:** By Rev. Edward F. Garesche, S.J., M.A., LL.B.; 207 pages; W. B. Saunders Company; Canadian Agents, McAlinsh & Co. Limited, Toronto; price \$1.50.

In reading this book one finds it inspirational, lifting hospital work "from the daily round the common task," to a higher intellectual outlook; emphasizing the necessity of the spirit of religion, culture and courtesy surrounding the patient. In this age of materialism, it is a delight to read such a book—especially chapters entitled "Culture in the whole Hospital," and "The Centre of the Hospital Universe." The chapter on "The Future of Nursing Education" appeals to all superintendents of nursing schools, in the fair, square way the subject is handled, showing knowledge of nursing schools' knotty problems and present day weakness, which all superintendents are striving to eradicate.

The book shows sympathetic understanding of all hospital activities, and is recommended for thoughtful reading by the nursing profession.—M. F. BLISS.

**Personal and Community Health:** By Clair E. Turner, Associate Professor of Biology and Public Health in the Massachusetts Institute of Technology. Published by C. V. Mosley Company, St. Louis, 1926.

The author prepared this book for the student at the university, college, or professional school. It deals with the health of the individual and of the community. Public health being considered from the standpoint of what the college or professional man who is not a sanitarian, needs to know in order to protect his family and meet his responsibility as a citizen.

The keynote of the book is contained in two sentences: "Your health depends not upon what you know, but upon what you do"; "To learn the facts regarding health of individuals or communities is an educational, perhaps a cultural process, but unless your habits of life and the quality of your citizenship are improved thereby you have missed the greater part of the educational opportunity."

Chapters I to VI deal with personal hygiene, each chapter including more than is ordinarily included under the main topic; for example, that on "The Hygiene of Action" deals with ocular hygiene, breathing, speaking, bathing and clothing.

The chapter on nutrition stresses particularly the effect of the emotions upon digestion and quotes freely from Cannon's work, "Bodily Changes in Pain, Hunger, Fear and Rage."

The remaining eleven chapters discuss all of the various phases of community hygiene, including communicable diseases, immunity, school hygiene, industrial hygiene and public health administration.

There are two appendices, the first one being a copy of the facts regarding the more common communicable diseases as presented by a committee report of the American Public Health Association.

There is quite a complete bibliography which is arranged according to chapter topics. There are fifty-three illustrations and an index.

The language of the book is not too technical for the ordinary reader, and the facts are presented in a useful and interesting way.

This book is hardly adequate for a textbook on hygiene for use in schools of nursing, but as a reference book and for use in supplementary readings it would be most helpful.—M. S. FRASER.

**Directing Learning in the High School:** By Walter S. Monroe. Published by Doubleday, Doran and Company, Garden City and New York, 1928.

This recently published book should prove as valuable to the teacher in the School of Nursing as to the High School teacher, in that it supplies the laws and uses the terminology of modern educational psychology in a most practical way.

The author in his introduction says that the recent contributions of educational research are probably sufficient to justify the appearance of a book which makes the results of investigation accessible to prospective teachers. He also says that it was written for the purpose of guiding and assisting the reader in arriving at a clear understanding of the task of teachers, and is confined rather closely to a treatment of problems relating to instructional procedures.

Many problems vital to the teacher are considered at some length, some of these being, the nature of learning activity, motivating the doing of learning exercises, directing the formation of specific habits, engendering of general patterns of conduct which will include ideals, attitudes, interests and taste, adapting instructional procedures to individual differences, and directing and supplementing learning activity outside of the recitation period.

Some good suggestions for learning to read rapidly are given in a brief, clear-cut form, as is also advice regarding the teaching of study habits, with a number of suggested questions for a teacher to ask a class regarding their general procedure in studying assignments.

The author points out the importance of the teacher's example, saying that he should make evident his appreciation of the values he wishes his students to appreciate. He also says that the teacher should approach his task of securing a motive for the doing of learning exercises with the attitude that the students are not hostile toward school work, and that if appropriate learning

exercises are presented in the right way and at the right time, it will not be difficult to secure the necessary impelling force to get them done.

The last chapter gives very helpful advice and suggestions regarding lesson planning and also gives illustrative lesson plans.

The author acknowledges his indebtedness to such authorities on the philosophy and psychology of education as Dewey, Thorndike Bagley, Charters and Parker, and applies their ideas in a very helpful way.

The book is well printed, is interesting to read and should provide a very stimulating source of help to the teacher in a School of Nursing.—M. S. FRASER.

#### **Four Thousand Years of Pharmacy:**

An outline history of Pharmacy and the Allied Sciences, by Charles H. LaWall, Professor of the Theory and Practice of Pharmacy and Dean of the Philadelphia College of Pharmacy and Science. Published by J. B. Lippincott Company, Philadelphia, London and Montreal, 1927.

The author of this book points out that every calling, trade, art and profession has a history, and says that the influence of the past upon the present is in direct proportion to the wealth of tradition and of history that has been handed down through successive generations.

If this is true, the influence of the past upon the present of Pharmacy must be great indeed, for the author has given us a most interesting account of the development of this science, beginning with that of the ancient Egyptians and following it through the Grecian, Alexandrian and Roman periods; through the Medieval and Modern to the present time. He emphasizes the influence of the Arabians in having preserved the pharmaceutical art through seven centuries; he shows how for many years magic and superstition dominated both medicine and pharmacy, and also how the latter was influenced by Alchemy.

Short interesting sketches of the lives of the more famous men who studied pharmacy are given as well as accounts of the numerous struggles and laws to regulate the particular sphere of the apothecary and that of the physician.

Just enough of the history of general science and of some of the professions, arts and sciences most clearly related to pharmacy is given to enable the reader to orient himself in the particular period of which he may be reading. In this connection quite a lengthy chronological table is given which is very helpful.

The author is evidently interested in collecting what he calls "quaint and curious volumes of forgotten lore." The source

of much of his material is therefore original, as are also the sixty-four illustrations. There is quite a detailed bibliography, the references being arranged according to subjects. There is also a complete index.

While the book does not deal with the science of nursing, those subjects with which it does deal, are so closely allied to nursing that it should prove of great interest to nurses and to students of Materia Medica, and it would make a valuable addition to the library of a school of nursing.

—M. S. FRASER.

**Nervous and Mental Diseases for Nurses:** By Irving J. Sands, M.D., Associate in Neurology, Columbia University, N.Y., etc., etc. Philadelphia and London: W. B. Saunders Co. (Canadian Agents, McInish & Co., Ltd., Toronto); 12mo. of 245 pages, illustrated; 1928; price \$1.75.

One notices the appearance of an increasing number of text-books on Nervous and Mental Diseases for Nurses, betokening, doubtless, the increasing interest of both medical and nursing professions in a hitherto rather neglected subject.

This particular book is by an author of wide experience in the teaching of medical students and nurses. One of the book's advantages is evident at once and that is its reasonable size. Nursing in Nervous and Mental Disease is a special subject in the nursing curriculum and much of the material in a large book is unutilized.

The book opens with a well-illustrated chapter on the Anatomy and Physiology of the Nervous System. The exposition is concise and free from burdensome details such as mar many texts for nurses. The close relationship between the nervous and endocrine systems is given recognition in a chapter on the diseases of the ductless glands. A compact chapter sets forth the fundamentals of elementary psychology in its medical applications and adequate well-proportioned consideration is given to the commoner neurological and mental disorders.

Perhaps the most valuable portions of the book—the things that make it unique among its kind—are the special chapters devoted to the development of modern psychiatry and mental hygiene. In a day when real strides are being made in these fields, it is most important that the nurse should be correctly oriented both for her own sake and that of the interested public which she serves and has many opportunities to instruct.

The book is provided with a good index, is well printed and illustrated and well bound. It may be cordially recommended as a suitable text book for schools of nursing where its scope, compactness and freedom from padding will be appreciated.—A. T. MATHERS.



## News Notes

### BRITISH COLUMBIA

The annual meeting of the Graduate Nurses Association of British Columbia is to be held on April 1st and 2nd, 1929.

The quarterly meeting of the Graduate Nurses Association of British Columbia was held at the Royal Columbian Hospital, New Westminster, with the president, Miss K. W. Ellis, in the chair. Over fifty nurses were present. At the meeting of the nursing education committee Miss E. M. Forrest, of the Vancouver General Hospital staff, read an excellent paper on "Medical Asepsis," and Miss H. Randal outlined the facilities provided for its practice in various hospitals of the province.

The public health committee heard from Miss May Ewart an interesting account of a summer school course in school nursing at Teachers' College, Columbia University. The library committee was authorized to purchase suitable books for the public health nurses open shelf in the Provincial Library at Victoria, and to supply the librarian with the names of public health nurses to whom lists of books on hand should be sent.

At the general meeting a motion was passed assuring the Canadian Nurses Association that a sum of not less than \$2,000.00 would be collected by the British Columbia association towards expenses for the International Congress, 1929.

It was decided to include the Kelowna General Hospital training school for nurses in the list of schools approved by the council of the Graduate Nurses Association of B.C., as giving the three years' course of training without affiliation; graduates of this hospital are under the present regulations eligible for registration.

At the close of the afternoon session, the nurses were guests at tea of the Graduate Nurses Association of New Westminster, and members of the council were dinner guests of the Royal Columbian Hospital, and refreshments were served by the hospital at the close of the evening meeting, at which F. W. Howay was the speaker, "Just Words" being his topic, which he made very interesting.

### MANITOBA

BRANDON: The regular meeting of the Brandon Graduate Nurses Association was held at the home of Mrs. McGuire. Mrs. J. S. Pierce gave a talk on current events, and a very pleasant evening was spent.

Mrs. J. S. Pierce recently entertained the Brandon Graduate Nurses Association to a social evening. Mrs. Whitmore gave a

most interesting talk on her trip abroad, illustrated by some wonderful slides that Dr. Pierce had kindly collected.

### NEW BRUNSWICK

SAINT JOHN: The monthly meeting of Saint John Chapter Registered Nurses was held January 21st, 1929, in the Nurses Home at the General Public Hospital. Miss E. J. Mitchell, president, in the chair. Following a business session, Dr. V. D. Davidson gave a lecture on gastric and duodenal ulcers. A social hour concluded the gathering.

The General Public Hospital Alumnae held a very enjoyable bridge in the reception room of the Nurses Home, on the evening of February 5th, following a short business session. Miss McGrath, president, was general convener. Each member was asked to bring twenty-five cents and refreshments for one. These were served at the close of the evening.

CHIPMAN MEMORIAL HOSPITAL, ST. STEPHEN: Miss Florence Cunningham has been appointed instructor of nurses at C.M.H.

The new wing of the hospital is now equipped: the upper floor is occupied by maternity cases, and the superintendent and staff are most comfortably settled on the first floor.

Miss Lou Mersereau has been a patient at the Chipman Memorial Hospital.

The Alumnae of the Chipman Memorial Hospital are planning to furnish a room in the new wing. In January they held a successful food sale, the proceeds to be used for that purpose.

### ONTARIO

The annual meeting of the Registered Nurses Association of Ontario will be held in Kingston on April 4th, 5th and 6th, 1929.

Paid-up subscriptions to "The Canadian Nurse" for Ontario in February, 1929, were 1,167, six less than previous month.

### APPOINTMENTS

Miss Christine Inrig (Hamilton General Hospital, 1924), has been appointed Supervisor of Out Patient Department of Hamilton General Hospital.

Miss Anne Coutts has taken charge of Ward 7, Hamilton General Hospital.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Marguerite Waddell (1919), resigned from the Shriners Hospital, Montreal, and is in charge, First Floor, Private Pavilion, Toronto General Hospital; Miss Margaret MacInnis (1928), assistant supervisor, nose and throat operating room, Toronto General

Hospital; Misses Florence Booth (1927), and Kathleen Hollowell (1927), on the staff of the New York Hospital; and Miss Marion Piggott (1915), on duty in New York.

#### DISTRICT 1

The annual meeting of District No. 1, Registered Nurses Association of Ontario, was held on January 19th, at the Gartshore Residence, Victoria Hospital, London.

The morning session was given over to routine business, discussion of reports and election of officers.

In the afternoon a demonstration of Orthopedic work of the Children's Hospital was presented by Dr. George Ramsay, in which he described some of the early symptoms of deformities and paralysis which the trained eye of the nurse should detect. He also stressed the need of educating the public generally of how much can be done for practically all congenital and early deformities if early diagnosis is made. He referred to the unnecessary distress so often caused by children being brought just eight years too late!

This was followed by a very interesting performance given by the little patients under the supervision of their teacher, Miss Teasdall, showing the need of academic and vocational training for crippled children.

An address on "Professional Obligations" was given by Miss Jean Browne, in which she outlined in a very concise way how much the provincial and national associations mean to the individual nurse.

Dr. F. W. Hughes then discussed in a practical way the value of immunization against communicable diseases showing the reactions and tests on some children patients.

Miss Ermine Cumming, supervisor of the communicable disease department, continued this discussion by giving a few practical points to public health and private duty nurses for the care of infectious diseases in the home.

Luncheon was served by the local nurses, and the evening session took the form of a dinner at which the guest and speaker of the evening was Miss Jean Browne, who for her subject took "Public Health," tracing its history from its earliest beginnings and showing that although we live in a scientific age we are yet faced with an unnecessary sickness and death rate. She stressed the responsibility of the younger members of the profession as health educators, and referred to the contribution "The Junior Red Cross" had made in the field of preventive medicine. Miss Browne outlined briefly the programme and financial obligations in connection with the coming International Council of Nurses Congress.

**SARNIA:** On January 8th, 1929, the corner stone of the new wing of the Sarnia General Hospital was laid by Miss Margaret MacKenzie, chairman of the Hospital Commission, in the absence of the Honorary Lincoln Gordie, Provincial Secretary. This new

wing when completed will greatly increase the present hospital accommodation for Sarnia and surrounding district.

#### DISTRICT 2

**GENERAL HOSPITAL, BRANTFORD:** Miss Helen Holbrooke and Miss Aileen Mair have gone to Brooklyn, New York, where they will take up duties at the Beth Moses Hospital.

Miss Helen Potts, assistant superintendent, who has been confined to bed for the past couple of weeks, is able to resume her duties again.

Mr. E. Moule, manager of the Temple Theatre, entertained the staff and pupil nurses, as guests, at the play, "The Admirable Crichton," which was put on by the Rotary Club, in aid of the Crippled Children's Fund.

Misses Helen Ion and Patricia Saunders, have been relieving in the various departments during the winter months.

Miss Jessie Wilson, who is taking the course for teaching in Schools of Nursing, University of Toronto, visited in the city during the Christmas holidays.

Members of the Alumnae deeply regret the death of Miss Doris Small, which occurred on December 27th, following an attack of pneumonia. She will be greatly missed by a large number of friends.

#### DISTRICT 4

The third annual meeting of District No. 4 of the Registered Nurses Association of Ontario, was held in Hamilton, January 20th, with Mrs. Barlow, chairman, presiding.

After the chairman's address, which consisted of a brief resume of the year's work and a plea for a larger membership, Dr. Woodhall, of Hamilton, the speaker of the evening, gave an address entitled, "Present Day Treatment of Fractures." The speaker emphasized differences between present day and old-fashioned methods. Among modern methods he mentioned light weight splints, avoiding immobility of the injured part as much as possible, and the use of the X-ray before and after the reduction of the fracture. Many X-ray pictures, illustrating this excellent paper, were shown. A hearty vote of thanks was extended to Dr. Woodhall.

The annual reports were read and routine business was transacted. The election of officers resulted as follows: Chairman, Miss Edith Rayside, Hamilton; Vice-Chairman Miss Anne Wright, St. Catharines; Secretary-Treasurer, Mrs. Norman Barlow, Hamilton; Councillors, Misses Buckbee, Sutherland, Eva Moran, Hamilton; Margaret Park, Niagara Falls; Tassie, Welland; Ann Moyer, St. Catharines; Convener of Programme Committee, Miss Cameron.

**GENERAL HOSPITAL, HAMILTON:** Miss Evelyn Swayze (1923), is doing special duty in New York City.

Miss Grace Dunn (1920), is recovering from a thyroidectomy, and Miss Anna Coutts has recovered from her recent illness.

## DISTRICT 5

The annual meeting of District No. 5 of the Registered Nurses Association of Ontario was held in Toronto on January 29th, Miss Greenwood in the chair. The chairman spoke hopefully of reaching the objective in membership set by the campaign before the expiration of the given time. Miss Meiklejohn, the district's representative on the finance committee of the International Council of Nurses, reported an expected total of \$3,387.00. The election of officers resulted in the appointment of Miss Ethel Greenwood, chairman; Miss Gladys Hiscocks, vice-chairman, and Miss Alice Vernon, secretary-treasurer. Dr. Harvey Agnew, secretary of the Hospital Service Department of the Canadian Medical Association, a newly formed department designed to serve as a means of communication between hospitals throughout Canada, was the speaker of the evening. This department should be especially valuable to the smaller, isolated hospitals, which are carrying on independently, trying to care for the sick, and at the same time give an adequate nursing training. Miss Emory, president of the Registered Nurses Association of Ontario, spoke in her optimistic way of the affairs of the provincial association, and hoped all would try to attend the annual meeting in Kingston.

**GENERAL HOSPITAL, TORONTO:** The annual meeting of the Alumnae was held on January 30th, 1929, in the Nurses' Residence, Miss J. Browne in the chair. The minutes of the last meeting were read and adopted, and the election of new officers took place, with Miss Jean Browne as president.

A series of lectures is being held in the Medical Lecture Room at the Toronto General Hospital, two of which took place in February: "Asthma and Hay Fever," by Dr. Detweiler, and "Old Toronto," by Mr. T. A. Reid. The remainder of this series, "Mental Diseases," by Dr. Farrar, and "Alice in Wonderland," by Principal Hutton, will be held on March 4th and 11th respectively.

Members of the Alumnae who come to Toronto are asked to notify the new Corresponding Secretary, Miss Bailey, Ward G, Toronto General Hospital.

Mr. and Mrs. Ayrnes (Frances Webster, 1925), have returned from Negritas, Peru, South America, and will reside in Toronto.

Miss Margaret Duhnage (1918) has returned to Toronto from an extended trip to Training Schools in the States, to resume her position in the Training School Office of the Toronto General Hospital. The object of her trip was to observe the methods used for imparting a Public Health viewpoint to the students in training.

Miss Annie G. Creighton (1917), for some time after graduation in the P.O.R., and who left to take a position in New York, died after a short illness of "flu" and pneumonia, in New York.

## DISTRICT 6

The annual meeting of District No. 6, Registered Nurses Association of Ontario was held January 25th, at the Nurses Residence, Nicholl's Hospital, Peterboro, the president, Miss F. Dixon, in the chair.

The minutes of the last meeting and also report of the year's work were read by the secretary-treasurer, Miss L. Simone, and adopted. The president, Miss F. Dixon, gave a short account of the work done by the district association. Reports were received from the conveners of the various committees.

Mrs. Leeson, convener of finance committee, reported having collected \$100.00 from the nurses of the district for the purpose of entertaining foreign nurses at the International Congress of Nurses.

The officers elected for the coming year were as follows: President, Miss F. Dixon, Peterboro; Vice-President, Miss R. Bell, Port Hope; Secretary-Treasurer, Miss L. Simone, Peterboro; Councillors, Misses Walsh, Cobourg; Morrison, Lindsay; Collier, Belleville; McGrath and Anderson, Peterboro; Mrs. Smythe, Bowmanville; Private Duty Section, Miss Dawson, Peterboro; Nursing Education Section, Mrs. Leeson, Nicholl's Hospital; Public Health Section, Miss Jory, Peterboro; Representative, Registered Nurses Association of Ontario, Miss F. Dixon, Peterboro.

Miss F. Emory, Toronto, President of Registered Nurses Association of Ontario, and Dr. Neal, Peterboro, were special speakers.

After the meeting tea was served in the reception room of the Nurses Residence, with the nurses of the hospital Alumnae acting as hostesses.

**GENERAL HOSPITAL, BELLEVILLE:** The regular meeting of the Alumnae was held in the Nurses Residence on February 15th. It was decided to purchase a chesterfield for the Nurses Residence, also to give a sleigh drive, followed by a dinner, to the members.

## DISTRICT 8

**GENERAL HOSPITAL, OTTAWA:** A successful afternoon tea and bridge under the auspices of Ottawa General Hospital Nurses Alumnae, took place recently in the Hollywood Studio under the able convenership of Mrs. A. J. McEvoy. A record number of 360 were guests of the Alumnae.

Sister Mary Claire (Gray Nuns of the Cross), celebrated her Jubilee of 25 years in the Order. During that time Sister Mary Claire has been closely connected with the Ottawa General Hospital, which is conducted by the Gray Nuns of the Cross.

## QUEBEC

**CHILDREN'S MEMORIAL HOSPITAL, MONTREAL:** The regular meeting of the Alumnae was held in the Club Room on February 4th,

the president, Miss Watson, in the chair. Dr. R. R. Fitzgerald gave a very interesting lecture on the "History of Surgery" which was made more fascinating by a number of lantern slides of famous surgeons.

The regular meeting is held on the first Monday of the month.

The Graduating Class were the guests of the Senior Class at a dinner-dance, held at the Place Viger Hotel on February 9th, 1929.

Miss E. Thompson, who has been on the staff of the Bay City Hospital, Michigan, has returned to Montreal, where she has taken a position in the nursery of the Woman's General Hospital.

Miss G. Gough is visiting in Appleton, Wis., for two months with her parents.

Miss G. Cole is spending two months with her family in Kingston, Ontario.

Miss G. Sleeth has taken up residence in Montreal, where she is doing private nursing.

**WESTERN HOSPITAL, MONTREAL:** The annual meeting of the Alumnae Association was held in the Nurses Residence, January 14th, 1929, when the officers for the ensuing year were elected and other business transacted.

Miss Jane Craig spent a few days early in January at Lake Placid Club, Lake Placid.

Mrs. Cameron Gamsbey (Debra Starke), of New York, and her small son and daughter recently visited her parents in Montreal.

Miss Florence Martin recently visited her mother in New Glasgow, N.S.

Miss Violet Cross has resigned from the staff of the Medical Arts Hospital, Montreal.

Miss Grace Munro has been doing private duty nursing at Pinehurst, N.C., for some weeks.

Mrs. Ross Pennoyer (Florence McNie), who recently underwent a serious operation at the Montreal General Hospital, has returned to her home.

The sincere sympathy of the Alumnae is extended to the following members in their recent bereavements: Miss Bertha Birch, her brother; Mrs. Percy Robertson (Christine Rowley), her sister; Mrs. Victor Sargent (Miss Jean McArthur), her father; Mrs. Millar (Margaret Halford), her father.

**ROYAL VICTORIA HOSPITAL, MONTREAL:** Miss Frances Kirkpatrick (1924) is now in charge of the maternity department of the Seattle General Hospital.

Miss Ethel Currie (1921) has been appointed head anaesthetist at the Denver Presbyterian Hospital.

Mrs. G. W. Izard (Marie Beard, 1922), with her little daughter Louise, recently arrived from England to visit her parents, Mr. and Mrs. Frank Beard, until September, when she will rejoin her husband in Nigeria, West Africa.

**SHERBROOKE:** The regular meeting of the Graduate Nurses Association met with

Miss Wark at her sister's residence, Mrs. Forbes, Lennoxville.

Miss Buck, superintendent of Sherbrooke Hospital, has returned from a pleasant holiday spent in Florida.

Miss Alice Lyster has resigned her position as night supervisor, succeeded by Miss Mary Todd.

The engagement is announced of Phyllis May Galbraith to W. L. Reford Stewart, of Toronto.

**WOMAN'S GENERAL HOSPITAL, WEST-MOUNT:** Mrs. Isabel Robertson (1298), has accepted a position on the staff of the Alexandra Hospital, Montreal.

**GENERAL HOSPITAL, MONTREAL:** Recent appointments: Miss Alice Wells (1928), charge nurse in Ward K. Miss Inez Welling (1923), second assistant of the teaching department, replacing Miss Harris, who has recently been married.

Miss Marion Ives (1924), who has been in Boston following her return two months ago from St. Anthony, Northern Newfoundland, where she was superintendent to Sir Wilfred Grenfell's Hospital, is taking a post graduate course in Anesthetics.

At the annual meeting of the Alumnae the sum of \$500.00 was voted for the International Congress of Nurses.

The Sick Benefit Fund disbursed \$2,760.00 during 1928; Home benefit, 16 members; Hospital benefit, 52 members.

The sympathy of the members is extended to Miss Dorothy Jones in the loss of her mother; Miss Madelaine Scott, her mother; Miss Mildred Affleck, her father.

## SASKATCHEWAN

The Saskatchewan Registered Nurses Association will hold their annual convention and institute in Saskatoon on April 3rd, 4th and 5th.

Red Cross nurses in Saskatchewan are interested in raising funds to help defray expenses of a nurse from central Europe to the International Congress at Montreal.

Miss Annie Findlay, Kenora graduate, has joined the Red Cross Nursing Staff, and assisted during February at Broderick.

**SASKATOON:** Miss Hoffinger has resigned from the staff of St. Paul's Hospital, to join the hospital staff at Aneroid, Saskatchewan.

## VICTORIAN ORDER OF NURSES

Miss Ethel Cryderman, of Toronto, has been appointed to the position of Central Supervisor of the Victorian Order of Nurses for Canada.

Recent staff appointments: Miss Flora Macdonald (Vancouver General Hospital), North Vancouver, B.C.



Miss Helen Hivey (Yarmouth Hospital), the district of Sackville, N.B.

Miss Anna MacKenzie (Victoria General Hospital, Halifax), nurse-in-charge in New Glasgow, N.S., with Miss Dora Ashkins as assistant.

Miss Faye Saunders, Halifax, N.S.

Miss Dorinda Ellis (Children's Memorial Hospital, Montreal), Saint John, N.B.

Misses Alice Reed (Victoria Hospital, London), Evelyn Pibus (Montreal General Hospital), Marguerite Pauze (Notre Dame Hospital), Montreal.

Resignations: Miss S. J. Leveson (Vancouver General Hospital), from Edmonton.

Miss Henrietta Macdonald, from New Glasgow.

Misses M. Shredrick, Margaret McCarney and A. Jowsey, from Montreal. The marriages of Misses Shredrick and McCarney are announced. Miss Jowsey has gone to Nassau, where she will be engaged in private duty nursing.

#### C.A.M.N.S.

##### MONTREAL

The annual meeting of the Montreal Association of Overseas Nursing Sisters was held January 21st, 1929, when the following officers were elected: President Mrs. Stuart Ramsay; Vice-President, Miss N. Enright; Secretary, Mrs. W. N. Petch; Treasurer, Miss B. A. Moores; Convener, Flower and Sick Visiting Committee, Mrs. A. O. McMurtry, Representative to the Last Post Fund, Miss M. McDermott; Members of the Executive, Misses M. Galbraith, M. Gall and M. Raynor.

Activities during the past year were reported: Two social evenings—a musicale and bridge, and an address by Col. Clarke, D.S.O. A wreath was placed on the Cenotaph on Armistice Day in the name of the Association. A donation was made to The Last Post Fund, also to the Vancouver Memorial Window. Flowers were sent, and visits made to sick members.

It was decided that the Association would entertain during the Congress, visiting nurses who served in the war, and a bridge will be held on March 12th, 1929, in order to raise funds for this purpose.

The secretary was instructed to send the following letter to all overseas nurses clubs:

The President, Nurses Overseas Club.

Dear Sister:

#### Re: All Canada Association

With further reference to our previous communications regarding the formation of an "All Canada Association" of overseas nursing sisters: it was suggested that the most opportune time for organization would be during the International Congress of Nurses, which will be held in Montreal in the month of July, 1929, and you are hereby requested to send a delegate with authority to represent your club. Kindly advise as early as possible the name and address of your representative.

(Signed) Montreal Association of Overseas Nursing Sisters, E. E. Petch, secretary, 396 Olivier Avenue, Westmount, P.Q.

The Montreal Club is aware of Associations at Vancouver, Edmonton, Winnipeg, Toronto, London and Halifax, and should there exist any other overseas nursing sisters clubs throughout the Dominion who have not been officially notified, kindly write the secretary for information.

##### VANCOUVER

The annual meeting of the Vancouver Nursing Sisters' Club was held in the Women's Building, and the following officers elected for 1929: President, Mrs. Bradford Heyer; Vice-President, Miss Matheson; Secretary-Treasurer, Miss Jane Johnstone; Executive Committee, Mrs. Patterson, Mrs. Crickard, Miss Rice; Convener of Committees, Miss P. Stewart; Sick and Visiting Mrs. Danby-Smith; Press, Miss Beatrice McNair.

During the past year the Vancouver Nursing Sisters' Club placed a Memorial Window in the new Canadian Memorial Chapel, at a cost of \$350. This window represents a Canadian Sister in full service uniform, and is in memory of the Canadian Nursing Sisters who gave their lives during the Great War. Many of the members of the club attended the opening services of the Chapel on November 11th, and also on Sunday, November 25th, 1928, when the Sisters' window was dedicated by the Rev. Dr. E. D. McLaren.

#### ANNUAL MEETINGS

Graduate Nurses Association of British Columbia, April 1 and 2, 1929.

Saskatchewan Registered Nurses Association, with Institute, April 3, 4 and 5, 1929, in Saskatoon.

Registered Nurses Association of Ontario, April 4, 5 and 6, 1929, in Kingston.

#### MESSAGES RE "THE CANADIAN NURSE"

"I am always very pleased to get the magazine and find the articles very interesting and up-to-date."

"I would not like to miss a copy of 'The Canadian Nurse'."

"I have received a great deal of help and pleasure from 'The Canadian Nurse' and would not be without it."

## BIRTHS, MARRIAGES AND DEATHS

## BIRTHS

CAMPBELL—On November 25th, 1928, at Regina, to Mr. and Mrs. C. R. Campbell (Mary Newton, Regina General Hospital, 1921), a daughter (Shirley Anne).

CHALMERS—On January 5th, 1929, at Sudbury, to Mr. and Mrs. Allan Chalmers (Agnes Connor, Toronto General Hospital, 1923), a daughter.

GARVIE—Recently, to Mr. and Mrs. Garvie (Irene Reid, Toronto General Hospital, 1917), a daughter.

MACLAREN—On January 6th, 1929, at Halifax, to Mr. and Mrs. Stuart R. MacLaren (nee Marjorie Coburn, Lady Stanley Institute, Ottawa) a son.

McELIGOTT—On January 6th, 1929, at Montreal, to Mr. and Mrs. P. J. McElligott (Leola Johnston, Homeopathic Hospital, Montreal, 1922), a daughter (Leola Patricia).

McINTOSH—On October 2nd, 1928, at Belleville, to Mr. and Mrs. James McIntosh (Ruth Elizabeth Coulter, Belleville General Hospital) a son (William Alfred).

MERRITT—On January 12th, 1929, to Mr. and Mrs. A. Stanley Merritt (Georgie Small, General Public Hospital, Saint John, N.B., 1914), a son.

MILLETT—On November 7th, 1928, at Saskatoon, to Mr. and Mrs. W. E. Millett (Anna Viletta Armstrong, Saskatoon City Hospital, 1927), a son.

MOORE—On February 1st, 1929, at St. Stephen, N.B., to Mr. and Mrs. Sydney Moore, of Calais, Maine (Hazel Upton, Chipman Memorial Hospital), a son.

ROSS—On October 28th, 1928, at Regina, to Mr. and Mrs. D. D. Ross (Irene McLanders, Regina General Hospital, 1921), a daughter (Sheila Margaret).

## MARRIAGES

BROAD—BURROWS—Recently, at Saskatoon, B. Burrows (St. Paul's Hospital, Saskatoon, 1926), to A. Broad.

CARR—ONKEN—On December 25th, 1928, at Saskatoon, Mamie Onken (Saskatoon City Hospital, 1927), to Cecil Carr, Laura, Saskatchewan.

CLEARY—DUFFY—On November 21st, 1928, at Montreal, Margaret Duffy (Woman's General Hospital, 1928), to Peter Joseph Cleary.

CUBITT—SMITH—On December 18th, 1928, at Saskatoon, Ethel Smith (Saskatoon City Hospital, 1923), to John Cubitt. At home, Chauvin, Alberta.

FOLEY—ADAMS—On January 15th, 1929, at Toronto, Mary Alma Adams (Montreal General Hospital, 1919), to William John Foley. At home, Ottawa.

GRILLS—JONES—On January 22nd, 1929, at Regina, Dorothy Claire Jones (Regina General Hospital, 1925), to John Grills, of Regina.

HARDING—VINCENT—On December 22nd, 1928, at Ann Arbor, Michigan, Teresa Vincent (Amasa Wood Memorial Hospital, St. Thomas, 1912), to Sherman Harding, Marion, Michigan.

HAVERTY—STOWE—On January 17th, 1929, at Toronto, Mabel Stowe, to H. Edward Havery, of Shaunavon, Saskatchewan.

KINDLE—FERGUSON—Recently, at Saskatoon, L. Ferguson (St. Paul's Hospital, Saskatoon, 1925), to W. Kindle.

LA RUE—FRENCH—In March, 1928, at Shanghai, China, Dorothy French (Hamilton General Hospital, 1923), to G. P. La Rue.

MUIR—AUSTIN—Recently at Paris, Ontario, Ersula G. Austin (Brantford General Hospital), to David Muir. At home, Yorkton, Sask.

MULLINS—WOOD—On December 29th, 1928, Louise Wood (Hamilton General Hospital, 1927), to Stanley Mullins, Hamilton.

ORRILL—HANNAH—On August 30th, 1928, Flossie Hannah (Belleville General Hospital), to John Francis Orrill.

PARKINSON—KING—On September 21st, 1928, at Montreal, Kathleen D. G. King (Montreal General Hospital, 1921), to Albert Parkinson, of Birkenhead, England. At home, Aylmer, P.Q.

RUSSELL—STEWART—On January 7th, 1929, at Montreal, Anne Stewart (Montreal General Hospital, 1928), to James Gordon Russell. At home, Cap Chat, P.Q.

SUTCLIFFE—BEAL—On February 6th, 1929, at Toronto, Shirley Beal (Hospital for Sick Children, 1904), to F. W. Sutcliffe, of Lindsay, Ont.

TOBIAS—FESSENDEN—On January 12th, 1929, at East Orange, N.J., Edith Juanita Fessenden (Royal Victoria Hospital, 1914) to Alfred Tobias, of New York.

VALENTINE—RICHARDSON—On January 23rd, 1929, at Saint John, N.B. Hazel Marion Richardson (Saint John General Public Hospital), to John Henry Valentine, of Montreal. At home, Regina.

## DEATHS

CREIGHTON—Recently, at New York, of influenza, Annie G. Creighton (Toronto General Hospital, 1917).

GRAVEL—On December 27th, 1928, at Ottawa, Mabel Gravel (Ottawa General Hospital, 1920).

SMALL—On December 27th, 1928, Doris Small (Brantford General Hospital), from an attack of pneumonia.

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### CONTENTS

PAGE

EDUCATION OF THE CRIPPLED CHILD - - - - -	<i>Ethel Teasdale</i>	171
HEALTH PRESERVATION THROUGH ADEQUATE DIET - - - - -	<i>Sister Irene Marie</i>	176
THE COST OF HOSPITAL SERVICE - - - - -	<i>Dr. G. Harvey Agnew</i>	181
AFTER THE CONGRESS—THE MARITIMES - - - - -		183
DEPARTMENT OF NURSING EDUCATION:		
TRAINING SCHOOL PROBLEMS - - - - -	<i>C. E. Guilloid</i>	187
DEPARTMENT OF PRIVATE DUTY NURSING:		
ANTE-OPERATIVE AND POST-OPERATIVE CARE - - - - -		191
DEPARTMENT OF PUBLIC HEALTH NURSING:		
A DAY WITH THE SISTERS OF CHARITY IN ZAGREB - - - - -	<i>Mary Millman</i>	194
REGIONAL CONFERENCE, VICTORIAN ORDER OF NURSES - - - - -		195
BOOK REVIEWS - - - - -		196
INTERNATIONAL COUNCIL OF NURSES—PROGRAMME AND GENERAL ARRANGEMENTS - - - - -		197
NEWS NOTES - - - - -		202
OFFICIAL DIRECTORY - - - - -		211



# Education of the Crippled Child

By ETHEL TEASDALL

I have been at a loss just how to christen this talk, but that should not give any trouble, remembering "All's well that ends well," and "What's in a name?" However, it would be much better for all concerned if you had a faint inkling in the beginning of the line I should like to follow. If the subject were given as "The Child as a Patient" you would naturally expect a scientific discourse on diseases of children and their treatment, and that would be absolutely impossible from this source. Still, that suggested subject might be suitable if we were to consider the viewpoint of old Doctor Parry, of Bath, who said: "It is much more important to know what sort of a patient has a disease than what sort of a disease the patient has."

But it is really after the disease has been treated in a scientific, professional manner, and during the long periods of convalescence, we are about to consider: not what to do till the "doctor comes," but rather "what to do after the doctor goes." A simple talk of a few suggestions of practical occupational therapy, just what any nurse would be able to do without any formal equipment for any patient, and because that field in itself is immense we wish mainly to confine our attention to the subject and its relationship to children as patients.

The problem of how "to keep the child amused," to get his mind off himself, etc., has been an age-old question. We all know that health itself suffers when one thinks too much about it. Health even requires

something of interest to which one can turn. We remember about the fate of the centipede:

"The centipede was happy quite  
Until the frog, in fun,  
Said 'Pray which leg comes after which?'  
Which wrought his mind to such a pitch  
He lay distracted in a ditch  
Considering how to run."

So we all naturally fall back on the saving grace of work to keep us contented and happy—occupational therapy—remembering that the best way to live well is to work well. It is not the abundance of work that we require, but rather the mood of work, and the work must be great and pressing enough for us to lose ourselves in it.

After the nurse has watched her patient through the various stages of his illness, the convalescent period may be just as, if not more trying. But as this is the age of specialists, we must study the case in hand from many angles and meet it accordingly. First, there can be no set nor staid programme in the treatment of convalescents. Each case presents an individual problem, requiring attention to suit his variously different needs. This is the time when the nurse has the great opportunity to prove her artistic personality as well as her professional worth. By artistic I mean the ability to meet these convalescent whims with a charming grace and so make them stepping stones to the gateway of health, and if your training has been so dogmatic that you shelve your personality when you take a case, take it out and be yourself: no other person will do.

We love children, and one of the most talked-of reasons for this affection is that they are so "natural," and because they possess this attractive attribute they are very quick to detect shams and applied veneer in

(Presented along with a musical drill and demonstration by the patients of the War Memorial Children's Hospital, London, by their teacher, Miss Ethel Teasdall, at the annual meeting of District 1, R.N.A.O., January, 1929.)

those with whom they come in contact. The teacher in the school is the point of criticism of the well child, and this honour is transferred to the nurse when the child is sick. So to establish the first bond of relationship, be natural and human for you must win the confidence of your patient. Remember the things you loved to do as a child and do them over



Pauline was born with a deformed foot. She was admitted to the hospital in 1926, when an operation to readjust the bones of the foot was undertaken.

again with your little patient. Talk to them and tell them about those times, for children are always keen for a human interest. Cheerfulness, happiness, contentment, enthusiasm, and faith, above all, have a good effect on health; their opposites have a bad effect.

With a sick child, one perhaps first thinks of books. The range and choice of books is so vast, the old and yet ever new delights which are ours for the searching, all provide a limitless field: a deep mine of pleasure. Love books and you will never be alone, but you must have that love and appreciation before you are able to pass it on. I might copy a long, tiresome list of books for various ages, from some publishing house catalogue, which we would all promptly forget and which would be as uninteresting as one of the biblical "be-gat" chapters. However, there is a book by Anne Carroll Moore, of the New York Public Library, called "Cross-roads to Childhood." It is a splendid list and review of books for children, middle-aged children and teen-age people, as well as universal literature: a readable, entertaining

catalogue of books covering a vast area of interests.

A safe guide is to let the reader's interest act as a selective factor in the choice of reading. This rule may be applied to children, too, with guidance and sometimes coaxing, as was the case of the visiting teacher who met with many difficulties on her first call to a new pupil. The boy was physically crippled, and worse than that his mind was crippled also with hideous, antagonistic barriers to every outside helpful advance. This call was not a pleasure: asking what subjects he liked to do in school work, he gruffly replied that he didn't like any—Spelling? Arithmetic? Reading? Geography?

"I hate it."

"Why, you don't hate the whole world, do you?"

"Yes, I do."

"Do you hate Africa?"

Well, he wasn't so sure about that, so it was from Africa that the point of contact was made and through stories of that dark and dismal continent a bright gleam of interest in all his studies was established, leading to a totally different viewpoint



The above photo shows Pauline in 1927, her foot restored to normal through surgery, massage and daily exercises.

and attitude towards all life. Still, we are taught in our Methods of Teaching to begin with something the child knows and is interested in, and to proceed to the new and unknown.

This case was vastly different from the boy who was just as badly crippled, but who had been taught right from the first of his illness that everything, even the seemingly uneventful

daily happenings, was an adventure, and lessons with him were so easy.

Convalescent children usually love their school work, so a work book and a pencil and their own school books do help a lot. They feel that they are keeping up with their companions in school, and that in itself is a good thing. The nurse can supervise this school work, for the patient is very willing to go on with a little direction. Then there may be letters to write, and even tiny tots like to do this, even if they are not able to write all alone, only with the nurse's helping hand. Sometimes rhymes may be thought out: these may not be able to

breathing dragons to disturb the sleeping hours of an impressionable mind. Don't read too long; in fact, never carry any entertainment to the point of fatigue.

Then there is that age-old idea of story telling without the aid of the printed page. A more intimate and lovable way of companionship—for the ideal audience is one little child. Perhaps after you tell your patient a few of the old familiar stories he may make up a few to tell you. A good story-teller must know the story and the audience. Earliest childhood, from one to five years, requires stories of familiar things and rhymes, mid-



War Memorial Children's Hospital.

qualify as good poetry, but it does pass as good fun for the convalescent, and to find happiness in the doing is the aim. Herbert Spencer says in his "Education": "The truth is that Happiness is the most powerful of tonics."

Linked with the question of books comes the thought of reading aloud. A harsh voice is difficult to listen to when one is well, but it is a thousand times more irritating to the ears of the sick. Cultivate a soft, well modulated speaking tone, read slowly enough to make it easy for the patient to catch every word without strain. Speak the words without muttering and if you have a choice of a book or story, select something happy, no dreadful giants and fire-

dle childhood, six to nine years, tales of active imagination. At the stage of advanced childhood, ten to twelve years, when memory is so active, true stories of adult life are asked for.

However, reading aloud and story-telling present only a small place in the great field of occupational therapy. There are card games of all sorts, weaving, wood and paper work, basketry, book-binding, sewing, the hobby of making various collections. Susan E. Tracy has written a practical manual for nurses and attendants called "Studies in Invalid Occupation," where hints for occupation during periods of quarantine are given and suitable employment is suggested for patients in restricted positions as well as many ideas for

impatient patients, who are not accustomed to this business of being ill, even for a short time.

Here are some general rules:

1. Occupation should be new. This is especially for little children to call forth their interest, a new book to crayon, something new to do, for there is an air of exciting intrigue about a new thing.

2. One occupation should not be followed to the point of fatigue. Don't make things too difficult. Give the child the joy of accomplishment with-

are considered the educator's most important aid, and the intimate connection between hand and brain is recognized by physiologists and psychologists.

Some occupations may be used as remedies for certain physical defects. The tread pedal on small weaving looms, for the older children, or the pedals of the sewing machine may be aids to exercise muscles of the limbs. We have many uses in our school room for the typewriter—to help stiffened fingers to move more read-



A part of the contributions received by the hospital in 1927 provided this Roof Play Ground, which has been of untold benefit to these little patients.

out the strain and stress leading to irritability, no small nor tedious work.

3. The work should be useful, avoid aimless work for even children like to feel a definite goal in the doing of any occupation.

4. The work should lead to an enlargement of the patient's mental horizon, a study and interest in associated things.

5. The nurse should participate in the occupation and show an interest in it.

6. The patient should be encouraged by praise and even necessary criticism should be sugar-coated, for back, well back, always remember that you're dealing with sick children and they have naturally more temperamental reactions than normal children.

7. It is better for a patient to do even bad work than none at all.

The restless hands of little children

ily, for a certain amount of push is necessary to bring the keys down, as well as a new and novel way to learn even dull spelling. Some of the pupils have been able to follow the set lessons for the touch system, giving a start towards after school employment, where office work, sitting at a desk, would be the most desirable form of earning a living, owing to a crippled condition. Basketry is also very good for what "ails us," aside from the joy of the finished work. Certain precision is required to cut the base from the beaver-board, the drilling of holes for the reed brings in the use of another tool, the actual pulling of the reed, thus shaping the basket, then the painting and finishing. The placing of pegs in peg boards involves the muscular exercise of picking up and pushing in, as well as teaching the recognition of colour. The stringing of large wooden beads, even the handling and the building of



blocks, all lead to certain desirable muscular control and development. The tossing and catching of a large light rubber ball, playing a toy piano or a toy tune on a real piano, modelling in clay or plasticine, all help hands that have been paralyzed.

Working with plasticine is an ideal occupation for any child, and as an easy, satisfying means of self-expression it ranks very high. Paper tearing or cutting free hand of animals or any picture from common wrapping paper is good fun. Splendid puzzles may be made by cutting up picture post cards. Interesting things, such as dolls' beds, carts or furniture for the dolls' houses, may be manufactured from discarded match boxes. Scrap books, developing a sense of ownership, may be started. Every boy goes through the period of stamp collecting. Paper folding and paper construction work need no tools except a pair of scissors and a little paste.

I remember one little boy was entertained for some time with a paper windmill he had made, and the blowing to keep the mill turning was "just what the doctor ordered." Blowing bubbles was another good game for this case. Crayons and colouring are always a source of profitable pleasure to the children in bed.

If children during their period of treatment are compelled to remain still, as in cases of cardiac trouble, or children who are required to be in casts, let them make things that they can play with and move: cardboard people or animals that move and change with the aid of paper fasteners and yet are light enough for the child to handle without strain of fatigue.

Sewing and knitting are good for these patients in restricted positions, and we have found that even the boys like to sew when the stitches are simple and the pattern interesting.

So we could go on through long pages, discussing the educational and helpful physical value of many occupations, also ever remembering that to keep the child happy and contented we must keep him busy. We must be able to utilize the material at hand to transform a tiresome, long day into a short one of interesting things to be accomplished.

Just because a child cannot use his legs is no excuse for all the rest of his wide-awake, lively little self to be still. Help him to forget his disability, never let him imagine for one moment that you think he is in a bad way or he'll imitate your viewpoint at once, and that means he is lost. "Keep on keeping on" is the slogan of the International Society for Crippled Children, and it's a good motto for all of us.

Now just a word regarding the work for crippled children in general. We have advanced both in years and in attitude of mind from the time when the old Spartans discarded their afflicted ones, or the Puritans regarded such disabilities as acts of Divine Providence, and because Johnnie was lame then he was to remain that way for all time. Now we are all fully aware of the help that can be given to these afflicted ones. Enthusiasm is very infectious and we want you all to catch the germ, to let it grow wherever you may be: that is, an interest in the cause for crippled children.

(Illustrations published by courtesy of War Memorial Children's Hospital, London, Canada.)

## *Health Preservation through Adequate Diet*

By **SISTER IRENE MARIE**, Teacher of Household Economics, St. Vincent College, and Dietetics, Halifax Infirmary, Halifax, N.S.

At the outset, let us acknowledge that proper feeding is but one aspect of the health programme. But it is a very important one. Perhaps the preservation of the health of the adult depends more than we recognize upon an adequate diet. A faulty diet, long adhered to, is now known to produce physical deterioration, even though this physical deterioration may not be recognized until it is pronounced—and then it is often attributed to very immediate causes, whereas its true, though remote, cause was a deficient diet.

The period of best health for most people is from fifteen to twenty years. The powers of resistance and the capacity to digest food are greatest at that time. The ability to recover promptly from loss of sleep and fatigue fosters the idea that violation of the laws of Hygiene and Nutrition are of little importance. Young people over-eat of any palatable food, and eat at irregular intervals, with so little evidence of any unfavourable effect that they see no reason for giving thought to correct dietary habits. But this freedom from accountability for violation of the laws of Health does not last many years. There is an imperative need of taking, from infancy up, such a diet as will defer the onset of the changes characteristic of aging. For it seems necessary to attribute the rapid increase, during the past 30 years, of the so-called old age diseases—hardening of the arteries, kidney and heart degeneration—to modern dietary habits. Facts available seem to point to deficiency in food to account for poor teeth formation, faulty bone growth, faulty posture, as well as to a perverted appetite and a liking for sweets.

Perhaps there are more people at the present time interested in the subject of nutrition than ever before. It is not difficult to account for this; for with the increase in the knowledge of the subject which the recent years have

brought, has come a realization of its importance for health and longer life. Nor is our attention directed to new and strange foods. Our most common foods have taken on a new value in our eyes, as we have become acquainted with the dietary properties which they contain, of which we knew nothing a relatively short time ago. In general, we now know that if the diet does not provide the right substances in the right proportions the physiological processes do not run smoothly; that on an inadequate diet old age appears sooner than is necessary; and our bodies become a prey to diseases which are largely avoidable.

One might ask the reason underlying the newer methods of good research which the recent years have brought, and whether they are a natural outcome of conditions not met with years ago, or whether they are, after all, only the hobbies of faddists or over-zealous physiologists. Why, a short time ago, when the appetite was thought to be a safe guide to the selection of food, was an adequate diet secured without much planning? First, of course, the appetite was never, strictly speaking, a safe guide to good selection. It may call for excessive amounts of sweets, or of alcohol, for example. But it is true that when such foods as milk, eggs, butter, fruits, and fresh meat were easily available, the planning of an adequate diet was a simple matter. Modern conditions, the growth of large cities, with more and more people to be fed, caused the transportation and storage problems to be a big factor in food supply. Non-perishable, or less perishable foods came to be used more considerably than formerly—such foods as cereal grains and their manufactured products. The poor keeping qualities, under average conditions, of many of our best agricultural products, as grains, root, tuber, and green vegetables, have naturally caused the modern nation to rely upon cereal grains,

wheat, corn, and rice as staples upon which it depends for its chief food supply. These grains and their manufactured products, if kept dry, keep well for a considerable time, and are not, in general, attacked by bacteria and mold.

It is true that in past history, mankind has relied upon these dry foods as his staples in time of stress, as in winter in temperate regions and for maintenance in time of drought. But when transportation over long distance was of rare occurrence, the milling of these grains was quite a different process from that at the present time. Nearly every locality had its own mill; here, the whole kernel of wheat or corn was ground into flour; there was no problem of its keeping qualities, for families sent grain at short intervals to be ground as they needed it.

Our present-day diet differs from that of our ancestors mainly in four great respects:

1. We eat more cereal products.
2. We eat more refined cereal products.

3. We eat more sugar, a substance which contains no structural elements, no mineral elements, no vitamins, and which is valuable only for the production of energy. The profit in sugar and its manufactured products has led to an enormous increase in sugar consumption in our country and elsewhere, it being per capita about ten times that of a century ago.

4. We eat more meat. With the development of commercial refrigeration processes, cold storage meats can be purchased at any time. Formerly, people were dependent upon their gardens and local agriculture for their food supply.

It is only within the last twelve or thirteen years that any one could say just what constituted a satisfactory diet; but we now know definitely that the regular diet of a large portion of our people is falling short of maintaining satisfactory nutrition. Until recently, chemical analysis of food was thought to be sufficient to determine its value in the human dietary. Modern research workers have shown this to be

false. The chemist can determine the amount of fat, of carbo-hydrate, of mineral elements, of water. He can analyze for protein; but he cannot tell which are good, and which are poor proteins. Moreover, the vitamins, substances upon whose presence in the diet proper growth and health depend, are not revealed to the chemical analyst.

I should like to review briefly a few facts in the history of the development of our present-day knowledge of good values. It is necessary to classify foods according to their function in the body, as follows:

Those which serve as material for body building and repairing: PROTEIN, MINERAL MATTER, WATER.

Those which are oxidized in the body to produce energy for work and heat: PROTEIN, FAT, CARBOHYDRATE.

And those whose function it is to regulate body processes and support growth: MINERAL MATTER, VITAMINS, WATER.

This classification has only developed within the past century. The limited knowledge which we possessed in the middle of the nineteenth century is well illustrated in the views expressed by Beaumont in his book, "Physiology and Experiments," published about 1832. In Beaumont's opinion, there existed but one food stuff, or "aliment," as he called it, which he believed to be present in all food and to be dissolved out by gastric action in the stomach. With the development of organic and inorganic chemistry, there was established the fact that foods contained protein, fat and carbo-hydrate, thus disproving the "single aliment" theory. It was learned that the oxidation of these within the body yielded energy for heat and work. The laws governing energy metabolism were next developed. Soon there followed upon this, the development of a system for measuring the energy value of each nutrient; that is, the amount of heat which is actually produced by the oxidation of a unit of any of the nutrients. The heat evolved by the burning sample of food was measured by the large calorie,

which represents the amount of heat necessary to raise one kilogram of water one degree Centigrade, or one pound of water 4 degrees Fahrenheit. By experiment in the Bomb Calorimeter, it was determined that one gram of protein, oxidized, yielded approximately 4 calories of heat; one gram of carbohydrate, 4 calories, and one gram of fat, 9 calories. These values are known as **FOOD CALORIFIC VALUES**.

Today, we know that the proteins of all foods are not identical in dietary value. Of two foods containing exactly the same amount of protein, one may do much better service than the other. The protein molecule is a very complex one. Each is made up of a large number of smaller parts, called amino acids. Each protein in our food is different again from the proteins in the human body. Hence they cannot be utilized as they are eaten to build protein of the muscles and organs during growth, or for repair of waste. Before being utilized, they must be digested.

Digestion involves the splitting up of the giant molecules into about twenty kinds of amino acids. These are absorbed and recombined to make human proteins. So much do human and animal, and animal and plant proteins differ that there are thousands of kinds of proteins in the plant and animal world. The reason that proteins differ in dietary value is that all do not contain the entire twenty amino acids. If only one is missing, even though the nineteen be there, that protein, by itself, is incomplete, from a dietary standpoint. It is easy to visualize how protein from two sources, each lacking one of the essential digestion products, but each rich in the one in which the other is deficient, could be combined so as to form protein of a high value.

We now know that the protein of refined cereals, of peas and beans, when used as the sole protein of the diet, is incomplete for optimal nutrition. On the other hand, protein from milk, eggs, some vegetables, especially the edible leaves, as well as the glandular organs is of excellent quality. Fruits

contain little protein, and the tuber and root vegetables, unrefined cereal grains, and the muscle meats stand intermediate between these two.

Certain substances have been mentioned which are of the utmost importance in the diet, if it is to maintain health, and which are not revealed to the chemical analyst. These substances are classified as vitamins. Of four of them we possess considerable knowledge: namely, vitamins A, B, C, and D. The first named (A) is found dissolved in certain fats, and for this reason is frequently termed *Fat-soluble A*. The best sources of it among palatable foods are butter, cream, egg yolk and green vegetables, as spinach, beet tops, celery, lettuce, et cetera. *Cod Liver Oil* is rich in vitamin A. It is abundant in glandular organs, as in the liver, kidneys, and sweetbreads of animals; but it is very sparingly present in lean muscle meat. Vegetable oils do not contain it; it is destroyed by prolonged heating in the presence of air, but ordinary cooking does not seem to affect it to a great extent. Both children and adults require it. Its absence from the diet over a long period induces the development of a characteristic eye condition, known as *ophthalmia*, which may cause blindness and produce other complications of a grave nature. It never occurs when suitable amounts of butter or cream are used. It is of frequent occurrence among children, when fed exclusively on skimmed milk and cereal products. Just what vitamin A does in the body we do not know. There does not seem to be a great capacity for storage of the substance, although a small amount is stored probably in the liver. But we know that this vitamin is required for the maintenance of health in both child and adult. There is sufficient of it in certain natural foods to prevent any one suffering from want of it, if the diet is selected with reference to these natural foods.

Among human beings, particularly among rice eaters of the Orient, there has long existed a disease known as *beri-beri*, which has taken millions of



lives. In 1880, the Japanese navy was all but incapacitated because of it. It resembles polyneuritis in pigeons, and is a widespread degeneration of the nerves. The explanation of this disease most in favour is that it is a deficiency disease. Animal experimentation has shown that it can be induced in pigeons by feeding them rice, without the husk or peri-carp. exclusively, for a given period. A monotonous diet tends to produce it. Vitamin B is abundant in many of our common foods, especially so in the leafy vegetables, fruits, whole cereal and manufactured products of cereal grains. It is, moreover, very stable, and even excessive heat, such as is given in some forms of canning, does not tend to destroy it to any appreciable extent. Vitamin B is so abundant in most of our common foods that there is likely to be a deficiency of it in the diet only when it is restricted to a few articles of food, or when it is derived largely from manufactured products.

It is astonishing that the discovery of the substance, vitamin C, was delayed so long in view of the fact that its presence in the diet is absolutely necessary for the prevention of scurvy. This disease appears wherever human beings are for a length of time deprived of fresh, raw foods. It is of more frequent occurrence among children than it was before the development of the pasteurization of milk. Vitamin C, anti-scorbutic vitamin, being unstable to heat, is destroyed in the process of pasteurization. This is not intended as an argument against the use of pasteurized milk. Pasteurization is sound in principle, and is a safeguard to milk supply. But where it is used exclusively for children, scurvy can be prevented by the inclusion in the diet of orange juice, lemon juice or tomato juice. In fact, the disease can be prevented, and, if not too far advanced, can be cured, by eating fresh unheated vegetables, generally. To illustrate the importance of fresh, uncooked foods in the prevention of scurvy, Professor Hopkins is quoted as giving a very impressive account of what

happened at a large preparatory school in England in 1920. During the winter term at this school, the conduct of the boys grew vaguely unsatisfactory. The standard of work and play fell below normal, the boys became listless and irritable, and various forms of minor complaints were reported. No explanation offered was satisfactory. Throats were examined, drains flushed, and other hygienic measures were instituted, but nothing came to light. It was suggested that the diet be inspected. The boys were well fed. However, it was discovered that the diet provided nothing in the way of uncooked foods, and practically no greens. The shop where the boys had been accustomed to purchase fruit with their pocket money was closed. Upon a liberal introduction of fresh fruit into the dietary, the whole trouble disappeared. The school had been suffering from incipient scurvy, due to a lack of vitamin C. It was possible for this to be so, although the disease had not been recognized by its usual symptoms, because the presence of food which provides even minute amounts of this vitamin will defer the actual development of the disease for months.

Dr. McCollum relates an account of an examination which he made of the dietary of an institution for the care of negro children, where malnutrition existed. Their diet, during the period when growth should be proceeding at a rapid rate, consisted essentially of cereals, tubers, roots and muscle meats, the largest portion of their food supply being secured from wheat flour in the form of white bread. He was astonished at the absence of any scorbutic tendencies, since the diet did not provide any fresh, raw food. The cause of this immunity was soon discovered. Certain fruit vendors in nearby markets regularly donated lemons which were still sound, but which were likely to spoil before the next market day. It had been the custom to slice these lemons and give each child a slice. This one raw fruit was highly appreciated by the children, and served as their source of vitamin C.

Rickets is the result of faulty nutrition in young children. Animal experimentation has shown that the disease is not likely to occur when the diet contains a sufficient amount of the vitamin D, the anti-rachitic principle, or when the subject is exposed to direct sunlight. Research has also indicated that the optimum storage of calcium among children is made when the diet contains one quart of milk per day. Wherever agriculture thrives, and the growing of cereal grains and tubers is the most profitable form of agriculture, physical deterioration, as shown by stunted growth, defective and carious teeth, is likely to characterize the people.

Thus far our knowledge of vitamin E is very limited. It is not yet held that the influence which experiment has shown it to have upon the reproductive faculty of animals is duplicated in the case of human beings.

Mention has already been made of the fact that the presence of mineral matter in the body is absolutely essential to life, and that all of the foods, with four exceptions, contain it, to a greater or less extent. During the period of growth, these must be supplied in sufficient quantity and variety. In certain cases of malnutrition it is true that the actual trouble is with the assimilation rather than with the diet. Still, it is the opinion of many, notably Sherman, that a deficiency of calcium is the most common of all dietetic faults. When the full stature is reached, the need for a contained mineral income is lessened, although the demand for some always exists.

Experiments upon actual diets used in the average home, show that they contain considerably more phosphorus than calcium. Milk contains considerably more calcium than phosphorus. It is now believed that it is better to provide these two elements in relationships similar to those occurring in milk, rather than in those which most diets seem to contain. In this case, the white bread, potato, meat and sugar diet, so prevalent today, is too poor in calcium.

Iron is another mineral essential to life. Without it, the blood would possess no oxygen-carrying power. Iron has also been called the "key" with which the energy is released from the food. If this is so, it is evident that food should contain plenty of iron-protein compounds, found especially in egg-yolk, green vegetables, fruits, legumes, and in whole grains. An intestine probably interferes with the assimilation of iron. An improvement in this condition, together with the provision of nourishing foods rich in iron are usually sufficient to correct the lassitude, capricious appetite and indigestion, characteristic of chlorosis, often developed by adolescent girls.

Sulphur, another mineral, is utilized by the tissues, and the only food in which it exists in a utilizable form is in proteins which contain the amino acid, cystin. Protein then is valuable as the only source of sulphur as well as nitrogen.

In concluding, I would mention a type of diet suggested by McCullom and Simonds which can be recommended with the assurance that it will go a long way toward improving physical fitness. It involves the borrowing of the best elements from those several diets which have been thoroughly tested in human experience and have been found successful.

The first and most important principle is the extension of the use of dairy products. From a pint a day, there should be an increase to a quart of milk daily. This is the feature of the diet of pastoral peoples which has made them superior in physical perfection to all other peoples. The next principle is to remember that the leafy vegetables possess unique dietary properties. These have been the protective foods of the Asiatic people and have, by their use, offset the evils of a monotonous diet.

Their use, in liberal quantities, supplies valuable nutriment not available in milled cereals and tubers; also, it does much toward keeping the intestinal tract in a hygienic condition. Milk, too, might be mentioned; it serves a similar purpose. Through its en-

couragement of the growth of lactic acid bacteria, it checks the development of such bacteria as favour putrefactive decomposition of good residues. Milk is the one food for which there is no effective substitute, as was stated years ago, and as has been found to be true by modern experimenters. A third principle is that of taking daily a certain amount of raw food of vegetable origin as a safeguard against the lack of the anti-

scorbutic substance. If these principles are adhered to, the main features of an adequate diet will be supplied, and the remainder may be secured from the cereal, tuber, meat and sugar diet list. Infants and children, it has been pointed out, can be greatly safeguarded in their skeletal development by providing them at regular intervals with suitable amounts of Cod Liver Oil, and affording them an opportunity for out-door exercise and sunlight.

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## *The Cost of Hospital Service*

By G. HARVEY AGNEW, M.D., Secretary of the Department of Hospital Service,  
Canadian Medical Association

One hears a great deal nowadays about the exorbitant cost of hospitalization. The public press seems to delight in dwelling on this question and this attitude is reflected in the many open letters written by "victims" or their sympathizers and published in the daily papers. One frequently hears the demand, especially from Old Country people, that our hospitals revert to the methods of British and Continental hospitals, wherein the great bulk of the working class people obtain treatment for a mere pittance. Recently, the writer met a committee from the Labour Forum of one of the large cities, who had been appointed by their fellows to investigate hospital and medical costs. That their report will advocate radical changes may be expected, but, to their credit be it said, these men are studying the situation and have learnt many facts of which the general public are only too ignorant.

Judging by the assertions which are so frequently heard, we are led to the conclusion that the majority

of the general public do not realize the amount of money required to run the average hospital and to maintain the efficiency which these very people demand. Because the patient may have no appetite and may require little nursing does not warrant the frequent statement that the care of such a patient "did not cost the hospital anything." One would like to take such a critic through the costly laboratories of any modern hospital; through the great engine rooms of, say, the Ottawa Civic Hospital; to see the elaborate kitchens with their batteries of labour-saving devices in the big hospitals of Montreal, Toronto, Winnipeg, Vancouver and other cities; to see the water-softeners in the prairie hospitals and elsewhere, the great laundries with their steaming mangles and whirling extractors, the refrigerating plants, the store and supply rooms and other departments "behind the scenes." Such a trip would be a revelation and would go far to explain why several of our larger hospitals spend almost, or over, a million dollars in

maintenance alone. One Canadian hospital actually spends \$30,000 annually in interest charges on its capital indebtedness.

Few people realize that the employees in a hospital (not including the medical staff) frequently outnumber the total number of patients served. This is especially noticeable in hospitals with a high proportion of private beds, or with large paediatric, pathological, diagnostic, or dietary services. Were hospital salaries not comparatively low, the salary item alone would render hospital costs prohibitive. Yet, with few exceptions, hospitals are short of help. Were it not for the general use of labour-saving devices the personnel would be much larger and the costs would be correspondingly higher.

The average cost per patient per day in general hospitals throughout Canada is \$3.45. This is an exceedingly low figure when one considers the cost elsewhere and also the type of service given here. An analysis by our Department of Hospital Service of the returns upon which this figure is based is very interesting:

Under 50 beds .....	\$3.45
50 - 100 beds .....	3.34
100-200 beds .....	3.21
200-300 beds .....	3.47
300-400 beds .....	3.58
400 beds and over .....	3.69

One notes that the hospitals with the lowest maintenance are in the 100-200 group. These hospitals can buy to better advantage than their smaller neighbors, thus reducing their costs, and do not, as a rule, maintain the extensive pathological and biochemical laboratories and other diagnostic or therapeutic facilities which raise the maintenance costs of the large hospitals.

When one considers these costly, but necessary, facilities for diagnosis and treatment provided by the modern hospital, and when one realizes

that by these means countless lives have been and are being saved—lives that would assuredly have been lost without this modern equipment—we think, not of the high cost of hospital care but of the low cost of hospitalization. That costs are still too high for the average wage-earner is only too true, but the remedy lies, not in decreasing the efficiency of the hospitals, but in so augmenting their revenue by increased government aid or other methods that the thrifty, struggling citizen who is “down” does not have to carry part of the burden of the needy or the thriftless at a time when he can least afford it.

(From The Canadian Medical Association Journal, March, 1929.)

### NURSES ATTENDING THE CONGRESS OF THE INTERNATIONAL COUNCIL OF NURSES

Any nurse who plans to visit the Province of Ontario before or after the Congress and who wishes to become acquainted with the nursing field of Toronto and other points in Ontario is requested to please write to the Convener, Hospitality Committee, Registered Nurses Association of Ontario, Toronto General Hospital, Toronto 2, Ontario, stating the type of nursing observation desired and the approximate date of visit in order that her time may be planned to the best advantage.

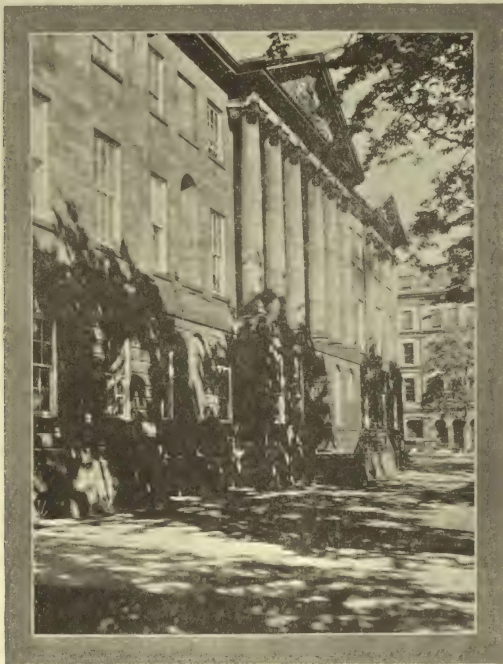
### HAVE YOU YOUR RESERVATION

Large numbers of requests for reservations for accommodation in Montreal during the Congress of the International Council of Nurses, July 8 to 13, 1929, are being received. If you are planning to attend the Congress and have not made application for reservation, kindly do so without further delay, thus assuring yourself of accommodation and also assisting the Committee on Arrangements in its task of finding suitable quarters for all those attending.



### *After the Congress---The Maritimes*

"There are forty different ways of reaching the Maritime Provinces and every one of them is right." Several delightful means are through the towering hardwood clad heights which rise on either side of the track, is one which the traveller never loses. Though the Gaspè Country



The Province House of Nova Scotia is considered to be the finest example of the Georgian type of architecture on the American Continent. In 1758, the first representative assembly in all Canada was convened here and in 1848 the first responsible government in the British Dominions Overseas.

Montreal; along the Maine border; and by sea to Saint John, Yarmouth or Halifax. But the scenic entrance is through the Matapedia Valley in the Gaspè Peninsula, for the memory of this journey, now along the banks of the beautiful river, now between

belongs territorially to the province of Quebec, geographically it is intimately related to the Maritime Provinces.

The Gaspè coast, because of its picturesque character, the beauty of colouring in its rocks, and the bold

unbroken sea line of towering cliffs has long been a paradise for the painter. For 200 miles it is dotted with towns and fishing villages where valuable cod-fishing is extensively carried on. Lumbering in the winter, fishing and farming alternately in the summer, has bred a bronzed and hardy-looking race of men and women of the proud type who go down to the sea in ships.



Historic Halifax. The clock tower in the Ordnance Yard.

The letters "C. R. C." (Charles Robin-Collas Company) still has a world full of meaning for these fishermen. Historically it was a semi-military company organized for the purpose of capitalizing the fishing industry. It was as influential in the East as the Hudson Bay Company in the West. Even today, it still retains much of the Old-World air about its management.

But this is only the gateway to New Brunswick, a land of lakes, rivers and bays, where curious shaped rocks and caves line the shore. This province is separated from the Gaspè by the Baie de Chaleur, one of the most beautiful havens in North America. The bay is well named, for the temperature

of the water is higher than at any other point along the Atlantic Coast. In the hinterland is the best salmon and trout fishing in the world, with the added attraction of countless numbers of moose, deer and bear.

Saint John is a "city compactly built together" for it was built upon a rock owing to the fact that it formed a natural fortress. Ever since its foundation it has been a great shipping port and in the days of wooden ships was a noted ship-building centre. It still has one of the largest dry docks in the world.

But no description of Saint John is complete without mentioning the Saint John River, with its extraordinary natural phenomenon—the reversing falls. As the river approaches the city it passes through a rocky gorge. Here occurs the conflict between the freakish tide, 26 feet high, and the river. At every tide there are two falls inwards and outwards, while the water is level for only about an hour in the 24 hours for boats to go through.

"Tides" immediately bring to mind the Bay of Fundy, one of the most interesting and valuable bodies of tidal water in the world. In addition to the usual virtues of good fishing and protected harbours, it automatically fertilizes enormous stretches of immensely productive lands, and performs "stunts" with its tides which hold travellers in spell-bound admiration. The tides rise over 50 feet and run at the rate of one to one and a half miles an hour. At Moncton occurs "The Bore," a solid wall of water three to six feet high which rushes up and as if by magic makes the broad mud-flats navigable. Near Moncton are also the famous Tantramar Marshes which are extraordinarily fertile.

Moncton also possesses the virtue of being en route to Nova Scotia, familiarly known as the "Land of Evangeline." From Grand Pré south to Yarmouth is called "The French Shore," revealed by distant glimpses of French white houses

strung along the shore for miles, like a great necklace of fairy domiciles. Acadia reincarnated lives again to itself with its old time language, many of its eighteenth century customs and garbs. Further south lies Digby, with its lovely curving waterfront, hilly background and its spick-and-span flotilla of pleasure craft in the offing: Bear River, with its luscious "Cherry Carnival;" and Annapolis Royal with its old grass-grown fortifications. This town is called the "Front Door" of Eastern Canada's premier orchard country, the home of the world-famous Gravenstein apple.

At the south-east point lies Yarmouth, with its lovely homes and hedge-lined streets carefully tended, but also with its stern coast and bleak lighthouse, and jutting rocks like dank haystacks after a rain, weed-grown and forbidding.

We round the corner of the point and come to the popular South Shore with its towns and villages from which come the hardy fishermen and daring sailors. It is the nursery which supplies not only the Canadian fishing fleet but also the American. Back from the coast there stretches to the interior a varied country of lakes and rivers, forests where the traveller can step from train to automobile to canoe without a break. This coast is the background for a hundred tales of privateering and sea adventure. For instance Lunenburg, in addition to being the chief centre of the Canadian Atlantic fisheries, is the home port of the "Bluenose," the famous champion of the International Fishermen's Races. In its vicinity are the famous "Ovens," deep caves into which the Atlantic rushes with the report of guns. It is said that an Indian once entered the largest of the caves in a canoe and emerged at Annapolis at the other side of the province. Chester also is a focus of interest for in addition to being a summer resort it is the last burying place of Captain Kidd's treasure.

From Chester we approach Halifax, one of the few cities in which historic memories and natural attractions are so combined. It is full of memorial tablets recording the valour and virtues of pioneers and warriors.

For a century and a quarter Halifax has been the chief British naval and military station on this side of the Atlantic. It has always played an extensive role in the sea-battles



The Old Fort at Ste. Anne, now Annapolis Royal, the oldest town in Canada.

of the past. Its naval and military history, its tragedies and romances would take a volume to relate. An interesting memento is the Citadel which crowns the heights of Halifax, and is one of the best preserved and interesting early fortifications of the continent.

The northwest arm of the harbour, a narrow inlet lined with beautiful homes is one of the finest aquatic play-grounds of the world. On either side of the entrance to the Arm are large iron rings fastened to the rocks to which in the old days an iron chain was attached to prevent hostile ships from entering.

Our way to Cape Breton Island

lies through the beautiful marsh lands of the Wentworth and Cumberland valleys. This island, or group of islands, is unlike any other part of America, in that the ocean, penetrates to the very interior of the island, forming the Bras d'Or Lakes, which stretch over several hundred miles. Their bosom is dotted with beautifully wooded islands and peaceful farms. To steam for hours through an island sea, invigorated by salt air, but remote from the

engagingly primitive, retaining those traits of proud self-respect and traditional hospitality typical of the Highland Scotch.

A contrast to this island is Prince Edward Island, "The Garden of the Gulf." It has no large cities, no great mountains, lakes or rivers. What the island has, though, is an air of quiet restfulness, an atmosphere filled with all that is invigorating, and peace and contentment everywhere.



Little guests at Rainbow Haven, Farmer Smith's Summer Camp for Crippled and Undernourished Children, reveling in the surf and sunshine of one of the many beaches of the province.

turbulence of the waves along this "Arm of Gold" is an experience no traveller can forget.

The city of Sydney is the centre for the coal industry and the steel works; it is the scene of the most extensive industrial development in the Maritime Provinces.

One of the great attractions of Cape Breton is the diversified nature of its scenery. The north coast of the island is as wild and ruggedly beautiful as the Bras d'Or Lakes are lovely and placid. It is much like portions of the coast of Scotland. There are tall cliffs and bold mountains, but cozy villages nestle at their feet. The people have mixed little with the outside world, and are

This island is the home of a unique and rapidly growing industry, black fox farming. There are over 600 fox ranches scattered over different parts of the island, which are a constant attraction for visitors.

The whole north shore of Prince Edward Island, for a distance of over ninety miles is a continuous series of fine white sand beaches. The water deepens very gradually and the bather is protected shoreward by the high sand dunes, rising from ten to forty feet. It is the Cozy Corner of Canada. The island people claim that, outside of Italy, there are no skies so blue as theirs, no sunsets so gorgeous, no landscape so colourful. Certainly it is a land that for restfulness would be hard to excel.



## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

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### *Training School Problems*

By C. E. GUILLOD, Superintendent, Maple Creek Hospital, Maple Creek, Sask.

How are we to obtain that environment in our training schools, which shall be conducive to the best interests of the patient, and at the same time to the highest development of the student nurse?

First of all, the training school must have certain inducements to make it attractive to the right type of student, who looks for breadth of vision in the teaching personnel and a sense of fair play in the hospital management. These are seen in provision of a suitable home environment and in a respect for individuality: meaning a proper assortment of work and allotment of recreation hours, as well as, scope for initiative and the realization of one's own ideals. If these can be recognized by the applicant she will not be concerned over the curriculum, about which she knows very little previous to entering a school for nursing; she will only expect that nursing education which will fully equip her for her future work as a graduate nurse.

Before receiving the prospective student the curriculum must be comprehensively and carefully planned: each subject, with the aims, subject matter and reference reading worked out, and assignment of hours made for studies of each year. Equally important is the arrangement of a correlated schedule of the practical work, to be demonstrated in the classroom and elaborated on the wards. Theory can then be given first, and practical work immediate-

ly following. In this way, the student nurse has a reason for all she does, and is taught to think for herself.

The next thing is to select the right candidate for nursing. To make a finished product good building material is required, and so, in training school work, accepted applicants should measure up physically, mentally and morally. More thorough physical examinations should be made than often is the case. Then students should be examined thoroughly again before being accepted into the school at the end of the probation term. It is a question whether hospitals, which, on account of limited facilities, are unable to give x-ray and functional tests, should conduct training schools. Follow-up examinations should be made the rule then at least once a year. No other student is under the same physical strain as the student nurse, because she earns her nursing experience by giving full service for her education, and strenuous physical demands are made on her while she is primarily a student.

Co-operation from the high schools in selecting the candidate for nursing would be a great assistance to the training school. I believe almost every training school is accepting only students who have passed the second year in high school, and soon, we hope four years in high school will be the accepted standard. In this way, the occasional student, who is a good junior nurse, but who falls below average in the second year of training, or who does not measure up

to third year standards, will be eliminated.

It is essential that the student nurse of today be very mentally alert, if she is to be bright enough to assimilate all the theory necessary to give her a grasp of the newer scientific principles of nursing and at the same time, to keep her head under moments of stress and heavy pressure of work. Deftness of hand is necessary for practical work and must be present to be cultivated, but an apt mind must go with it if the student is not to learn by mistakes, but is to absorb sufficient instruction to make her safe to her patients. Then, if theory precedes practice, she will have a growing knowledge, which will enable her to understand nursing procedures in detail, and to learn discrimination in dealing with all kinds of ailments and all kinds of people.

We find therefore that it is impossible for the student to measure up to all that is required of the modern nurse if she have not a sound educational basis to build on. On top of that, she must be a keen student and she must be deft in her handiwork, both of which come from exercise of concentration of mind. It is remarkable that the average student today enters a training school full of eagerness and ready to give exacting service—she has had two years high school we will say—and yet, she so often finds it difficult to concentrate on the theoretical side of her training. Instructors may try to arrange the curriculum to suit the student's needs by introducing as much of the project method as possible, but even then, there is often the difficulty of having to spend valuable time teaching the student fundamentals. While this problem is inevitable if students are taken in to training schools too young, I think it is probably more due to so many varied subjects being introduced into the preliminary

education, and to the fact, that the care and demands of the patients have perforce to come first in hospital life.

Factors added to these:

(a) Not enough graduate staff to relieve students while they are at class..

(b) Instruction being made of secondary importance, by crowding class-work into what should be recreation hours, instead of making it a definite piece of work in on-duty time.

(c) Too few study hours, and not enough time for discussion of practical and laboratory work on wards, arranged for.

Since the education of the nurse is of the heart, as well as of the head and hand, while she is being taught that nursing is an art, and that her practical work must have a certain artistic finish, she must be educated to realize that she is dealing with sensitive human souls, withal, she must be essentially human herself and possess the personal touch that brings healing to distraught minds as well as succor to ill bodies. A hospital is successful or otherwise according to the skill and kindness of its staff, and members of the staff who possess tact and grace in dealing with the emotional instability of the ill mind and at the same time, can render skilful attention to the body, are the really valuable people an institution cannot afford to be without. If in our training schools, greater emphasis is to be thrown on respecting the sensibility of patients and on satisfying all the varied needs of patients, we must have faith enough in our students to treat them with confidence, but first, we must carry to them a vision of the great appeal in nursing, which is to add something to the beauty and comfort of God's world.

Growth and development of heart principles can only take place under

right conditions of environment, and, if the student is to get right reactions, the atmosphere surrounding her should be wholesome and spontaneous, kindly and sympathetic. If all of these, it will be happy and stimulating, and the student who has entered hospital life full of zealous enthusiasm, so characteristic of the youth of today, dreaming of opportunities for purposeful activity and of service to others, will not have the lustre of her enthusiasm dimmed, but rather, it will grow brighter in the mutual confidence of teaching staff and student. Only so long as such wholesome relations exist can the student be encouraged to use her own initiative, and to find an outlet for her own creative thinking.

Factors contributing to the harmonious atmosphere necessary in training school life:

(a) Mental and physical health of instructor and student.

(b) Uniformity in methods of procedure throughout the institution.

(c) Constructive criticism when criticism is necessary, and full credit given for good work done. Monthly records of nurses in training could be used for discussion with students themselves with the help of the supervisor, and also the satisfaction of knowing they are receiving credit for work well done.

Vision and teaching qualities in instructors and head nurses are supremely necessary. The educational value of ward routine to a student nurse depends, not alone on her interest, her mental equipment and previous training, but also on the intelligence and vision of her teachers. Appointment of supervisors and head nurses who have an interest in teaching, as well as the knowledge to present the ward as a laboratory of learning to the student, is most important. The true teacher possesses an experimental mind and a sympathetic understanding of the student's problems and needs. Indi-

vidual capacities of students should be studied and opportunity afforded for development of natural ability. Attention should be constantly directed to the attitudes and ideals of the students with emphasis upon the opportunities for character building. Supervision must be of the best type, and the problem of how to use the practical experience on the wards to best advantage in the education and development of the nurse, be worked out on each ward. Our students assimilate a great many of their ethical principles from contacts on the wards. Does not this conception of supervision hold a challenge for all those entrusted with the education of student nurses, and have not the head nurses, as well as the instructor in the classroom, a responsibility as teachers?

The doctors on the hospital staff have a part to play in the education of the student nurse. They are watched, and their qualities gauged by the ideas of these enquiring young people, and it means much to the student nurse in her future nursing life, if the doctors she looks up to have the true teaching spirit, and do not fail in her eyes in their task of uplifting others.

The principal of the training school, not being a supernatural being, can hardly stand alone if she is to build up the type of training school that produces nurses of outstanding value. She should be chosen by the board of directors for her qualities of experience, and she must possess a spirit of leadership if she is to guide the students under her supervision. With these qualities she can never satisfactorily organize, or keep organized, a training school without the support of the board of directors.

My association with hospital boards has taught me that they are composed of the wonderful kind of people who often give their time unselfishly, to the thankless task of

helping their fellowmen. The responsibility resting on the directors of keeping the hospital in working order on limited financial resources is a heavy enough burden, without their feeling actively responsible for the education of the nurse. Because of this, and also, because the principal of the training school may not be doing her part in placing the training school feature of hospital life before them, and in giving them a comprehensive report of the workings of the school at regular intervals, the directors often do not realize that they are the ones who have the real responsibility of the training school resting on them.

If the board considers that it already has enough duties, it can see that a training school committee is appointed to govern the policies of the training school: a committee composed of members who have much more than an indifferent attitude towards the training school, members who are intellectually suitable and who have those far-seeing qualities which bring understanding. The appointment of this kind of a training school committee would be a hope, and perhaps sometime a reality, that the training school would be afforded a separate identity from the hospital, thus having it, not only on a separate financial basis, but made the whole-hearted endeavour of a group of people who understand the problems of a training school, and have a realization of what the training school of their own community should be.

### McGILL UNIVERSITY

The School for Graduate Nurses, McGill University, under the direction of Miss Bertha Harmer, R.N., M.A., has important announcements to make regarding plans and new developments in the educational programme for the coming year. The courses to be offered are planned to meet the expanding professional

needs and in accordance with the trends in the development of nursing education in Canada. Further particulars will be published in the May issue of the *Journal*, and detailed information will be available in the new Calendar of the School to be issued early in the spring.

### INTERNATIONAL COURSES

A booklet has been received announcing the International Courses, 1929-1930, under the direction of the Division of Nursing, League of Red Cross Societies. Two courses are offered; (1) Public Health for Nurses, (2) For Nurse Administrators and Teachers in Schools of Nursing. The League arranges these courses in conjunction with Bedford College for Women, University of London, and the College of Nursing, London.

One hundred and forty-one students from thirty-nine countries have followed one of these two courses since first started in 1920. Those wishing to attend one of the courses should make application to the Division of Nursing, League of Red Cross Societies, 2 Avenue Valesquez, Paris, 8.

### SIR VINCENT MEREDITH

Graduates of the Royal Victoria Hospital Training School for Nurses, Montreal, all over Canada, will learn with regret of the death of Sir Vincent Meredith, Bart., which occurred at his residence in Montreal on February 24th, after a lingering illness.

Sir Vincent was president of the hospital and a faithful visitor in the wards every Sunday morning for many years. He will be greatly missed, particularly in the Training School, in which he was keenly interested.

Sir Vincent took much pleasure in encouraging all kinds of healthful recreation among the student nurses and was most generous in his gifts to the Nurses' Home.



## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
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### *Ante-Operative and Post-Operative Care*

Demonstration of Surgical Technique for abdominal operation given by two intermediate nurses of St. Joseph's Hospital, London, Ontario, at the Course for Nurse Instructors, Victoria Hospital, June, 1928.

#### I

Preparation of ether bed and table.

While the patient is in the operating room it is the nurse's duty to prepare the anaesthetic bed and table, and have everything in readiness for the patient's care and comfort when he is returned to his room.

The patient is usually admitted to the hospital a day, or sometimes several days, previous to that assigned for the operation. This helps to avoid fatigue and excitement on the day of operation, allows the patient to become accustomed to his surroundings and hospital routine, and also allows the surgeon to receive reports from the different tests necessary before he will operate. From information thus obtained it may be found that surgical interference is contra-indicated, e.g. sugar in the urine, or a certain heart condition might also contra-indicate the risk of operating or the giving of a general anaesthetic, or at least indicate the need for very great care. From the examination of the blood it may be learned that the patient is a "bleeder."

It is the duty of the nurse to endeavour to allay any apprehensions the patient may have, to encourage and strengthen his confidence in his surgeon, in the nurses, in their unquestioned ability to meet every situation in the hospital, and in the adequate provision made for his proper care and recovery.

On the day previous to the operation three light but nourishing meals are usually allowed. No food is given after the evening meal. He is encouraged to drink extra water to help flood the tissues with fluid.

A cleansing enema is given the evening previous to free the lower bowel of its contents. That the bowel be empty is most essential for many reasons. If the result from the first enema is not satisfactory, a second or even a third should be given; the return must be clear.

The practice of giving cathartics previous to an abdominal operation has been discontinued by many surgeons, for several reasons. Free purging depletes the patient's strength too severely, robs the tissues of water, relaxes and lowers the tone of the intestinal muscles, predisposing to distention. Omission of the cathartic also insures a better night's rest. And this good night's rest is most essential, being one of the prophylactic measures for the prevention of shock.

The patient must be scrupulously clean. To avoid hurry and fatigue on the morning of the operation, especially if it is booked at an early hour, the cleansing bath is usually given on the previous day.

The preparation of the field of operation is made according to the orders of the surgeon in charge. Our routine is as follows: Surgical bath, seeing that an adequate area is prepared: a thorough washing with sterile soap and water followed by a second washing with clear water, then drying. Harrington's Solution is then applied followed by alcohol 50 per cent. Sterile dressings are applied, which are secured in place by a firmly pinned abdominal binder. This preparation is made on the night previous. On the following morning the dressings are removed, the abdomen painted with Tr. Iodine,

and the dressings and binder replaced.

Before going to the operating room the bladder must be emptied. Some surgeons have the patient catheterized to insure a complete removal of urine, especially if the operation is on the pelvic viscera.

All plates or removable bridge-work must be removed. No jewelry is allowed.

It is the practice of some physicians to give a hypodermic injection of morphin grs.  $\frac{1}{4}$  and atropin grs.  $\frac{1}{150}$  about one hour before going to the operating room. The morphin takes care of the psychic stage of anaesthesia, and the atropin helps to eliminate bubbling in the throat lessening the danger of aspirating mucus, etc., into the trachea.

The temperature, pulse and respirations are taken and recorded. All reports, treatments and medications given are charted, also the time at which the patient leaves his room for the operating room, and the chart accompanies the patient.

The patient must be well protected with blankets when being conveyed to and from the operating room, as the loss of body heat is another factor contributing to shock. A nurse always accompanies the patient to the operating room, and in our hospital the sister in charge of the floor on which the patient is located goes to the operating room also, and remains until the patient is anaesthetized.

## II

The patient is now returned to his room.

The ether bed has been prepared. The room should be quiet, the light shaded, warm, plenty of fresh air but no draughts. All hot water bottles are removed from the bed. If it is ordered that heat be applied to the patient the bottles must be placed between blankets. A nurse must never forget her responsibility in regard to hot water bottles around

an unconscious patient. The patient must be carefully lifted from the stretcher to the bed. A hard pillow is placed under the knees to prevent strain on the abdominal muscles. The condition of the patient, if cyanosed or of good colour, must be noted; also the time he is returned to his room. The pulse is taken frequently and its rate and volume recorded. Any change to a rapid, weak, compressible pulse must be reported immediately. The patient must never be left alone while under the anaesthetic.

If vomiting occurs the head should be gently turned to one side, and the vomitus basin placed where it will be most convenient. If the vomiting persists a gastric lavage will in all probability be ordered. A proctoclysis may also be ordered to be given as soon as the patient is returned to bed: in other cases it may be deferred till the patient has regained consciousness. A proctoclysis is the introduction of fluid into the rectum, drop by drop, for the purpose of supplying the body with fluid, helping to relieve thirst, and assisting in the re-establishment of peristalsis and the consequent freeing of the intestines of gases and toxic products.

A hypodermoclysis is also quite frequently ordered. This treatment is particularly indicated in cases where the patient shows symptoms of shock, or hemorrhage. A hypodermoclysis is the injection of normal saline solution, or Lock's solution, into the subcutaneous tissues. The usual site of injection is under the breast, but it may be given beneath the skin of the abdomen, in the thighs, buttocks, or in the axillary line. Sometimes, in cases of dehydration in infants it is given intraperitoneally. An adult patient can usually absorb from 500 to 1,000 cc. given slowly. The temperature of about  $112^{\circ}$  should be maintained throughout the treatment.

In cases of shock, in addition to the giving of the hypodermoclysis, one would add extra blankets to conserve the body heat, surround the patient with hot water bottles, and elevate the foot of the bed. The drug most likely to be ordered would be adrenalin (m. x to xv), though strychnin and digitalin may also be ordered.

Perhaps one of the most common complaints after a surgical operation is thirst. This may be relieved by giving the patient sips of hot water, and in some cases cold water is allowed, providing no more than sips are given. Sometimes small pieces of cracked ice are given, but with most patients this treatment seems to intensify the thirst. Frequent washing of the mouth with water or some mouth-wash proves refreshing. Some surgeons allow as much hot water as the patient desires, even before vomiting has ceased, because it satisfies the patient, relieves the thirst, and when it increases the vomiting, it tends to act as a lavage.

The patient must be kept quiet, for rest and quiet are Nature's great

restoratives. Morphin is usually necessary the first night, and occasionally the second night also, in order to relieve the pain or overcome restlessness. The nurse should see that all causes of discomfort are removed and simple measures taken to induce sleep before the morphin is given. In this way the patient derives the full benefit of the drug. If the patient complains later of gas pains quite frequently the passing of the rectal tube gives relief. But if the pains continue and some distention is present it is probable a colon irrigation would be the treatment ordered. However, this irrigation would not be indicated if there were any peritonitis present, as it increases the peristalsis and this would risk spreading the infection.

The patient must also be turned from side to side quite frequently, always seeing that the back is supported with a pillow. This changing of position aids in the prevention of adhesions and hypostatic pneumonia. If there are drainage tubes in the wound, the amount and character of the drainage must be carefully observed and recorded.



—By the courtesy of the Canadian National Railways.  
THE MONTREAL ART GALLERY.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *A Day with the Sisters of Charity in Zagreb*

By MARY MILLMAN, Toronto

Early in June, 1928, I spent a most interesting day in Zagreb, Jugoslavia, under the guidance of the Rev. Sister Blanda, who, with Sisters Nominanda and Sebastian, visited Toronto in 1927 to study nursing and health conditions. Sister Blanda is an instructor in the State School of Nursing in Zagreb, and Sisters Nominanda and Sebastian are in charge of wards in the hospital, where the nursing service is given by the Sisters of Charity.

I met Sister Blanda at the convent and was shown over the large and excellently equipped buildings, where they have, as day pupils and boarders, girls from the age of two years to normal school pupils. In this convent school stress is laid on building up a national spirit (for Jugo-Slavia consists of many national groups), partly by encouraging the national arts of embroidery, handicrafts, etc., the national songs and dances, and partly by making the children feel their responsibility for their new country. There were, as well as the usual academic classes, special classes for children who will have to earn their living with their hands, either for financial or for mental reasons. The church embroideries worked by the Sisters were so fine that they seemed too exquisite to be the work of the present day and to hint rather of mediaeval times.

Our next visit was to the women's penitentiary, which is just outside the city. Here are sent half the women prisoners whose offence is a penitentiary one. At the time of our visit there were between fifty and sixty women there, although a greater number is usual. Several pardons had been granted upon the birth of the king's second son. In charge of this institution are thirteen Sisters, whose method of caring for their prisoners is not one of weapons and punishments, but of education and kindliness. Most

of these women are in for murder or theft, and come from very poor homes with a low standard of education. Some are unable to cook properly or to hold a needle upon arrival. The Sisters train them in farm work and housework, so that on their release they may look after their own homes and know how to work for others. To judge by the delectable dinner served to us, the Sisters have succeeded in teaching cooking. Spinning, weaving, plain sewing, embroidery, cobbling—in short, all things that may be helpful in making them useful citizens are taught the prisoners. One remarkable feature that might well be copied by Canadian institutions is that each woman receives from one-quarter to one-third of the proceeds of the sale of her work. We left feeling that here was a penal institution which really was serving its purpose of reforming, and not merely punishing.

The Hospital for the Insane, a few miles outside the city, is not such a happy memory, although my admiration for the Sisters of Charity who are carrying on there is boundless. The hospital is over-crowded and has few modern facilities for treatment. The Sisters have had no special training, but their kindliness and fortitude under these trying conditions puts us lay people to shame.

The Hospital of the Sisters of Charity is in a most beautiful location, which should speed up the recovery of its patients. Few of the Sisters have had what we consider adequate training, but the adult ward supervised by Sister Sebastian and the children's pavilion under the charge of Sister Nominanda show the effects of the Sisters' special training in England, the United States and Canada.

The spirit of true kindliness and the desire to give adequate service which pervaded every type of work carried



on by these Sisters made a lasting impression on me, and I feel that, with the strong efforts being made by the three Sisters who have travelled, in time all the Sisters engaged in nursing will be able to add to their effectiveness

by entering the regular courses in the school of nursing. And, apparently, for years to come, the bedside nursing will be delegated to the religious orders, while the lay nurses undertake public health work.

## *Regional Conference*

The first Regional Conference for board members of the Victorian Order of Nurses was held in Hamilton on January 15th, 1929.

This pioneer educational effort was generously attended, fifteen of the twenty Western Ontario Associations being represented by 58 board members, 19 nurses and 7 representatives of other organizations.

At the morning session, Dr. Grant Fleming outlined the objects and possibilities of round table conference, making an appeal for a national point of view and an extension of service to cover opportunities hitherto overlooked or neglected: stressing the responsibilities of board members to know the work of the Order and interpreting it to the public.

The round table discussion then followed, with Dr. Reid in the chair. The problems presented included: how to provide nursing relief during the night, on Sundays and holidays for single-nurse districts; the best kind of organization and constitution of V.O.N. boards and committees; ways and means of obtaining good publicity in small districts for development of service and for securing funds; relationship of districts to Central Office and benefits derived therefrom; how best to care for chronics; central homes for nurses; the right basis for promotion and for salary increase. It was agreed by all that local branches should be willing to consider adding the cost of central supervision to their M.L.I. visits, and, if paid, to turn the difference into central funds. Each district was invited to appoint an active educational mem-

ber who would join the national Education Committee and serve as a new channel for information between the Central Committee and the local branch.

The afternoon session opened with a short play given by Miss Greenwood, of Toronto, and Miss Clarke, of Brampton, illustrating the difficulty at times met with in entering a home, the tactful manner in which this was overcome, and the opportunity for a second service which eventually opened up because of the informed friendliness of the Victorian Order nurse. Then followed papers on "Interlocking Health Services," by Dr. Fleming and Miss Greenwood for the voluntary nursing organization, and by Dr. Cannon, of Hamilton, and Miss Dyke, of Toronto, from the point of view of the Public Health Department. Medical practitioners, public health officers, and Miss Smellie then joined in a stimulating discussion. Exhibits from National Headquarters proved to be an outstanding addition to the occasion. Miss Percy's services in this and other connections should be gratefully recorded. The cost of this educational experiment, the value of which will doubtless be felt throughout all the districts represented, was inconsiderable, leaving a substantial balance to be applied to the expenses of the next conference, which will be held in April in Montreal for eleven of the adjoining districts.

To Dr. Helen Reid can be attributed a large share of the success of the conference. Both she and Dr. Grant Fleming devoted considerable time and thought to the planning and carrying out of the programme.

## Book Reviews

**Publicity for Social Work**, by Mary Swain Routzahn and Evert G. Routzahn. Published by the Russell Sage Foundation, New York, 1928. Price, \$3.00.

This book closely follows "Exhibit Planning," and it is hoped that others will soon follow, as there are a number of publicity ventures not featured here, as: publicity for children, periodical bulletins. It would be interesting to have the authors' more extensive opinion on the value of moving pictures in publicity.

No training school yet exists to prepare social workers for publicity work, therefore they have to depend on literature written by different people.

In "Publicity for Social Work" the writers keep before their readers the fact that the persons whom the social worker desires to inform do not wish to be furnished with such knowledge, as a rule. Hence the important factor in publicity is to create a desire for such information. Social workers are interested in selling the things they are doing, and want to do, to the public; but they have little conception how to approach groups. They try to sweeten the pellet, but the public chokes. To the public, the language of the social worker is so much gibberish and jargon. Too frequently the social worker uses terms to which the public has not been initiated.

To such workers this book contains many practical suggestions founded on years of experience. Prior to the writing of this book, the Routzahns had written many pamphlets on Publicity and were connected with the National Conference of Social Work and many other social work organizations. Evert Routzahn had also served as editor of the Educational and Publicity Department of The American Journal of Nursing and "Better Times" Magazine. At one time he was instructor of Publicity Methods in the New York School of Social Work. Hence the advice given is well founded and the material for the book has been drawn from all branches of social work.

The book is clearly written and there is no superfluity of language. From the detailed descriptions of methods necessary to attract and hold public attention, to obtain good-will and response, the writers carry the reader along to publicity for social work with the newspapers and the competition with hundreds of other interested groups for prominent space in them, also publicity in other printed matter as handbills, leaflets, folders, etc., with their decorations and illustrations and the distribution to the public of such. This is followed by advice on the conducting of meetings, exhibits and intensive campaigns that the spirit of the public may be aroused and fitting action taken.

Nowadays there is so much literature crowding the market, with little thought of the individuals to whom it is going, that the worker often not realizing that every group requires a different mode of approach, that some such system as that outlined here will need to be followed, fail to establish with the public the relations that they so desire.

—Florence Robertson.

**Communicable Diseases for Nurses and Mothers**, by Albert G. Bower, M.D., Glendale, California; Edith B. Pilant, R.N., Los Angeles General Hospital. Published by W. B. Saunders Co., London and Philadelphia. Canadian agents, McAlinsh & Co., Ltd., Toronto. Price \$3.00.

A text-book which every graduate nurse in active work will find a very useful addition to her book-shelf.

Dealing very clearly and concisely as it does with the various symptoms and complications peculiar to each infection, it is a practical reference book for those who wish to "brush up" on methods of procedures in home or institutional nursing.

For student nurses in conjunction with their course of lectures on Communicable Diseases or while taking their practical work in the wards it will add much to the interest of this particular branch of the training.

—Frances E. Welsh.

## *International Council of Nurses*

The Congress which meets in Montreal will be held under the distinguished patronage of their Excellencies the Governor-General of Canada and Viscountess Willingdon.

It is expected that the Board of Directors will meet from July 1-3, and the Grand Council, July 5-7. Special religious services for members of the Council are being arranged for Sunday, July 7th.

The Committee on Programme have submitted the following progress report for the programme:

### MONDAY, JULY 8th

2 p.m.—

#### GENERAL SESSION

Chairman—Miss Nina Gage, president, International Council of Nurses.

The President's Address.

Report of the Fifth Congress of the International Congress of Nurses.

Report of Secretary.

Report of Treasurer.

Report of Committee on Arrangements.

Report of Committee on Programme.

Report of Grand Council.

Reports of all Committees.

5.15-6 p.m.—

Films, Congress Headquarters.

8 p.m.—

#### OPENING SESSION

Chairman—Miss Nina Gage, president, International Council of Nurses.

#### Addresses of Welcome—

His Excellency the Governor-General of Canada.

The Archbishop of Montreal and Chancellor of the University of Montreal, Monseigneur George Gauthier.

The Premier of Quebec, Hon. L. A. Taschereau.

The Mayor of Montreal, Mayor Camilien Houde.

The Chancellor of McGill University, Mr. E. W. Beatty.

The President of the Canadian Medical Association, Dr. A. T. Bazin.

The President of the Canadian Nurses Association, Miss Mabel Hersey.

#### Response to Addresses of Welcome—

Miss Nina Gage, president, International Council of Nurses.

### TUESDAY, JULY 9th

9.30 a.m.—

#### GENERAL SESSION

Chairman—Miss Clara D. Noyes, first vice-president, International Council of Nurses; director, Nursing Service, American Red Cross.

Roll call by countries.

Reports of affiliated organizations (in order of affiliation):

The National Council of Nurses of Great Britain.

The American Nurses' Association.

The Nurses' Association of Germany.

The Canadian Nurses Association.

The Danish Council of Nurses.

The Nurses' Association of Finland.

The Nosokomos, Holland.

The Trained Nurses' Association of India.

The New Zealand Trained Nurses' Association.

The National Federation of Belgian Nurses.

Exchange Scholarships — Miss Alice Lloyd Still, matron, St. Thomas's Hospital, London.

3 p.m.—

#### MEETINGS OF SECTIONS

##### Nursing Education Section

Chairman—Miss Lillian Clayton, president, American Nurses' Association; director, School of Nursing, Philadelphia General Hospital, Philadelphia, Pa.

The Preparation of a Curriculum—Dr. E. S. Ryerson, secretary of the Faculty of Medicine, University of Toronto.

Trends and Development in Vocational Education—W. W. Charters, Ph.D., Professor of Education, University of Chicago, Illinois, U.S.A.

The Community Need in Relation to the Education of the Nurse—Mlle. Chaptal, president, The National Association of Trained Nurses of France.

Note—Discussion will follow the presentation of above subjects.

##### Public Health Section

Chairman—President of New Zealand Trained Nurses' Association.

Developments in the Public Health Field—Dr. G. B. Roatta, director of dispensaries, Florence, Italy.

The Red Cross Nursing Programme—Mrs. Maynard Carter, chief, Division of Nursing, League of Red Cross Societies.

Representative appointed by the International Red Cross Committee.

Note—Discussion will follow the presentation of above subjects.

#### Private Duty Section

Chairman—President, The Nurses' Association of Germany.

The Status and Problems of the Private Duty Nurse—

Asia—Miss Agnes Chan, superintendent of Nurses, Wesleyan Hospital, Fatsan, Tung, China.

Australasia—Speaker appointed by the Nurses' Association of Australia.

Africa—Miss A. Gordon, matron of the Victoria Nurses' Institute, Cape Town, South Africa.

Europe—Miss Else C. Kaltoft, Denmark.

America—Miss Janet M. Geister, director at Headquarters, American Nurses' Association, United States.

Note—Discussion will follow the presentation of above subjects.

5.15-6 p.m.—

Films, Congress Headquarters.

8 p.m.—

#### GENERAL SESSION

Chairman — Mrs. Bedford Fenwick, founder, International Council of Nurses.

"The Watchword"—Mrs. Bedford Fenwick.

Introduction of Newly Affiliated National Organizations.

Greeting from Pioneer Members—

Miss Lavinia L. Dock, United States.

Miss Margaret Breay, Great Britain.

Miss Mary A. Snively, Canada.

(Additional speakers may be added later.)

The Future—

Miss M. A. Nutting, Emeritus Professor of Nursing Education, Teachers' College, New York, U.S.A.

### WEDNESDAY, JULY 10th

9.15-10.45 a.m.—

**Round Table A**—The Need of Education in Mental Nursing in the General Nursing Curriculum.

Chairman—Miss S. C. Hearder, matron, Bethlehem Royal Hospital, London, S.E.

**Round Table B**—Utilization and Organization of Teaching Services in Various Public Health Activities not under School Control.

Chairman—Mlle. Cecile Mechelynek, director of the Visiting Nurse Association of Belgium.

**Round Table C**—Economic Aspects of Nursing Education and Nursing Services.

Chairman—Miss Nellie X. Hawkinson, dean, School of Nursing, Western Reserve University, Cleveland, Ohio, U.S.A.

**Round Table D**—Specialized Training for Private Duty Nurses.

Chairman—To be appointed by the Nurses' Association of Germany.

11 a.m. to 12.30 p.m.—

**Round Table E**—The Public Health Nurse and Social Work.

Chairman—Miss Alma C. Haupt, R.N., associate director, Rural Hospital Division, Commonwealth Fund, New York, U.S.A.

**Round Table F**—Text and Reference Books for Nurses.

Chairman — Miss Zefira Majdrakova, Bulgaria.

**Round Table G**—The Place of Preventive Medicine in the Curriculum of the School for Nurses.

Chairman—Miss J. Romanowska, president of the National Council of Polish Professional Nurses; supervisor of the Rural Health Centre, Skierniewice, Poland.

**Round Table H**—Staff Education.

Chairman—Mr. Kuo Jung Hsun, operating room supervisor, P.U.M.C. Hospital, Peking, China; chairman, Headquarters Building, Committee of Nurses' Association of China.

2 p.m.—

#### GENERAL SESSION

Chairman—Miss Nina Gage, president, International Council of Nurses.

University Schools of Nursing—Miss Anna Goodrich, dean, School of Nursing, Yale University, New Haven, Conn., U.S.A.

Leadership—Speaker to be appointed by American Nurses' Association.

The Nurse as a Citizen—Sister Bertha Wellin, member of Swedish Parliament; president of the Swedish Nurses' Association.

5.15-6 p.m.—

Films, Congress Headquarters.

### THURSDAY, JULY 11th

9-10.30 a.m.—

**Round Table A**—Maternal Care.

Chairman—Miss Margaret Breay, vice-president of the British College of Nurses.

**Round Table B**—Administration of and Instruction in School Wards in Hospitals not under School Control.

Mlle. Chaptal, president, National Association of Trained Nurses of France; director, Madisson École d'Infirmières Privées, Paris.



**Round Table C—Red Cross Nursing.**

Chairman—Mrs. Maynard Carter, chief, Division of Nursing, League of Red Cross Societies.

**Round Table D—New Ideas and Devices in the Nursing Care of the Patient.**

Chairman—Miss Healy, S.R.N., assistant superintendent, Central Welfare, Dublin, Irish Free State.

10.45 a.m.—12.45 a.m.—

**GENERAL SESSION**

Chairman—Miss Jean I. Gunn, second vice-president, International Council of Nurses; superintendent of nurses, Toronto General Hospital, Toronto, Canada.

Reports of Affiliated National Organizations. (In order of affiliation.)

The Nurses' Association of China. (Report given by Miss Shih Hsi En, general secretary, Nurses' Association of China, Hankow.)

The Norwegian Nurses' Association.

The South African Trained Nurses' Association.

The Bulgarian Nurses' Association.

The National Association of Nurses of Cuba.

The National Association of Trained Nurses of France.

The National Council of Trained Nurses of the Irish Free State.

The National Council of Polish Professional Nurses.

Reports of National Organizations affiliated at Montreal Congress.

Reports of the Associate National Representatives.

Reports from Other Countries.

3 p.m.

**MEETINGS OF SECTIONS****Nursing Education Section**

Chairman—Miss Lillian Wu, president, Nurses' Association of China; superintendent of nurses, Red Cross Hospital, Shanghai, China.

Legislation as Related to Nursing—Miss E. M. Musson, chairman, General Nursing Council of England and Wales.

State Supervision in Schools of Nursing—Miss Adda Eldredge, director of Nursing Education; secretary, State Board of Nurse Examiners, State Board of Health, Madison, Wisconsin, U.S.A.

The Advisability of Standardizing Nursing Education—Speaker appointed by the Nurses' Association of Germany.

Note—Discussion will follow the presentation of above subjects.

**Public Health Section**

Chairman—Mlle. J. Hellemans, president, National Federation of Belgian Nurses.

The Citizen in Relation to the Public Health Programme—Dr. Helen Reid, Montreal, Canada.

The Study of the Normal Child as a Preparation for Public Health Nursing: Physical Aspects — Mlle. Grenier, France.

Mental Aspects — Miss Winnifred Rand, Merrill Palmer School, Detroit, Michigan, U.S.A.

Discussion opened by Miss Mitchell, matron of Lady Buxton Home, Claremont, South Africa.

**Private Duty Section**

Chairman—Miss Charlotte Munck, president, The Danish Council of Nurses.

Developments in Private Nursing—Miss Isobel Macdonald, secretary, Royal British Nurses' Association.

The Financial Aspects of Medical and Nursing Services—Miss Elizabeth Fox, national director, Public Health Nursing Service, American National Red Cross, Washington, D.C., U.S.A.

Note—Discussion will follow the presentation of above subjects.

5.15-6 p.m.—

Films, Congress Headquarters.

8 p.m.—

**GENERAL SESSION**

Chairman—Miss Mabel Hersey, president, Canadian Nurses Association; superintendent of nurses, Royal Victoria Hospital, Montreal, Canada.

The Scientific Method in Social and Health Work—Dr. Julius Tandler, professor of the University of Vienna and Health and Welfare Commission of Vienna.

The World's Health—(Speaker not yet assigned.)

**FRIDAY, JULY 12th**

9.15-10.45 a.m.—

**Round Table A**—The Co-operation between Sister Tutors and Ward Sisters in the Training of the Student Nurse.

Chairman—Mrs. L. L. Bennie, president of the South African Trained Nurses' Association.

**Round Table B**—Nursing in Relation to Mental Hygiene from the Standpoint of the Community.

Chairman—Miss Katharine Tucker, general director, National Organization for Public Health Nursing, New York, U.S.A.

**Round Table C**—Health of Student Nurses—Sister Andrea Arntzen, superintendent of nurses, Ullevaal Hospital, Oslo, Norway.

**Round Table D**—Community Organization for Health Work.

Chairman—Miss H. L. Pearse, superintendent, School Nurses, London County Council, England.

Speaker—Miss H. Viney, secretary, Local Branches, College of Nursing, England.

#### Round Table I—Government Nursing Services.

Chairman—Miss Elinor D. Gregg, chairman, Government Section, American Nurses' Association; supervisor of nurses, United States Indian Service, Department of the Interior, Office of Indian affairs, Washington, D.C., U.S.A.

11 a.m.-12.30 p.m.—

#### Round Table E—Recreation and Other Activities of the Student Nurse.

Chairman—To be appointed by the nurses' Association of Finland.

#### Round Table F—The Purpose, Scope and Arrangement of Practical Field Work in the Training Course in Public Health Nursing.

Chairman—Miss E. K. Russell, director of Public Health Nursing, University of Toronto, Canada.

#### Round Table G—University Relations in Schools of Nursing.

Chairman—Miss Mabel F. Gray, director of Department of Public Health Nursing, University of British Columbia, Vancouver, B.C., Canada.

#### Round Table H—In What Cases Can Visiting Nursing Be Substituted for Private Duty Nursing?

Chairman—Miss J. Serton, secretary of the National Association of the District Nurses in Holland.

2 p.m.—

#### GENERAL SESSION

Chairman—Representative of the Italian Nurses' Association.

Adult Education—Speaker to be appointed by the American Nurses' Association.

The Need for Publicity in Nursing—Miss G. Cowlin, librarian, College of Nursing; or Miss M. S. Rundle, secretary, College of Nursing, England.

#### Rural Nursing—

Miss Nikica Bovolini, instructor, School of Nursing, Belgrade, Yugoslavia.

Miss Alexandra M. Wacker, State Hygienic Institute of Hungary, Budapest.

Miss Mary K. Nelson, Franklin County Memorial Hospital, Farmington, Maine.

Miss Elizabeth Smellie, chief superintendent, Victorian Order of Nurses for Canada, Ottawa, Canada.

## SATURDAY, JULY 13th

9.15 a.m.—

#### GENERAL SESSION

Chairman—Miss Nina Gage, president, International Council of Nurses.

Resolutions from Sections.

Resolutions from Round Tables.

Report from Grand Council.

#### General Business Session

(Agenda will be issued in later draft of programme.)

8 p.m.—

#### GENERAL SESSION

Chairman—Miss Nina Gage, president, International Council of Nurses.

The Interdependence of Nations—Hon. R. B. Bennett, Leader of the Opposition, House of Commons, Canada.

Introduction of newly elected officers.

#### Addresses of Farewell—

Asia—Miss C. F. Slater, The Dublin University Mission, Hazaribagh, India, former secretary of the Trained Nurses' Association of India.

Australasia—President or representative of New Zealand Trained Nurses' Association.

Africa—Mrs. L. L. Bennie, president of the South African Trained Nurses' Association.

North and South America—President or representative of the National Association of Nurses of Cuba.

Europe—Representative of the Nurses' Association of Finland.

HEADQUARTERS: The Montreal High School, University St., Montreal.

REGISTRATION: The registration bureau will be at headquarters. Registration will begin on July 5th and continue throughout the following week.

TRANSPORTATION: Reduced fares on the Identification Plan will be available for Canadian nurses attending the Congress.

Arrangements are being made with the president of each Provincial Nurses Association to issue identification certificates.

Any nurse wishing to take advantage of the reduced fare must apply to the president of her Provincial Association for her Identification Certificate which must be presented when purchasing ticket to Montreal.

Round-trip tickets at fare and three-fifths will be issued.

For some sections of Canada the Summer Tourist Fare or the usual Summer Rate may be less expensive than the Identification Certificate plan.

Information regarding dates of sale for tickets, and the names of those responsible for issuing Identification Certificates will be given later.

RESTAURANTS: Information regarding restaurants will be available at headquarters. Meals outside hotels need not cost more than

50c to 75c for breakfast, 75c for lunch and \$1.00 for dinner.

**EXHIBITS:** It is considered advisable that all exhibits should be in Montreal not later than May 15th. It will be a great help to the Exhibits Committee if all cases are clearly marked for the section to which they belong, viz.—Nursing Education, Public Health, etc. An inventory of the contents and instructions regarding their arrangements should be enclosed with the exhibits.

The exhibit room is to the left of the main entrance to headquarters, and can also be entered from the street.

The committee hopes to meet all requests for space and urges exhibitors to state clearly the amount of space desired when making application.

Address exhibits to Miss C. M. Ferguson, Convener of Exhibits Committee, Royal Victoria Hospital, Montreal.

**SOCIAL AFFAIRS:** Arrangements are not completed but those already planned include a visit to Ottawa, and a reception at Government House for the Grand Council, and a garden party on the last day of the Congress for the entire Congress membership.

**MEETING PLACES:** The Forum will be used for the large General Sessions.

The Montreal High School will be used for meetings of the Nursing Education Section, and rooms will be reserved here for special meetings of nurses from affiliated countries.

The Mount Royal Hotel will be the meeting place for the Public Health Section.

The Windsor Hotel will be the meeting place for the Private Duty Section.

**INFORMATION:** An Information Booth will be maintained at Headquarters, and will be open every day until 11 p.m.

A list of Convention members will be available for nurses wishing to locate friends.

**SIDE TRIPS OF INTEREST:** Information regarding interesting places to visit in and near Montreal will be placed in the folder given to each nurse on registration.

The Sub-Committee on Housing for the Congress announces that the supply of single rooms in the large hotels is now exhausted, but there are still a number of single rooms for reservation in private homes and in boarding houses, and a limited number in the smaller hotels.

Nurses who are planning to attend the Congress and who have not yet made reservation for accommodation are requested to do so without further delay.

While the single room accommodation is about exhausted there are still available in

the large hotels a number of large rooms which will accommodate two, three or four. These hotels with rates are:

**MOUNT ROYAL HOTEL** (all rooms have baths):

2 in a room.....	\$ 7.00 per day.
3 in a room.....	9.00 per day.
4 in a room.....	10.00 per day.

**WINDSOR HOTEL:**

2 in a room—	
With bath.....	\$8, \$9 or \$10.00 per day.
Without bath.....	6.00 per day.
3 in a room—	
With bath.....	10.50 per day.
Without bath.....	8.25 per day.
4 in a room—	
With bath.....	12.00 per day.
Without bath.....	10.00 per day.

**PLACE VIGER HOTEL:**

3 in a room—	
With bath.....	\$ 9.00 per day.
Without bath.....	7.50 per day.
4 in a room—	
With bath.....	10.00 per day.
Without bath.....	8.00 per day.

**N.B.**—Rates quoted above are for the room and not per person.

Rooms will be available in private homes and in boarding houses at the rate of from \$1.50 to \$2.00 per night per person. Rooms in small hotels will be about \$2.00 to \$2.50 per night per person.

Convents will be able to take care of quite a large number of nurses at from \$1.25 to \$2.00 per night per person, including breakfast at prices quoted. Accommodations will be beds in either dormitories or double rooms. The Y.W.C.A. has rooms at the same rates as the Convents.

Nurses coming in autos will find ample parking space.

**PLEASE NOTE:** It is necessary that each nurse when making application for accommodation state her name, address and official position. Application with this information should be made **at once** to the Executive Secretary, Committee on Arrangements, International Council of Nurses, Royal Victoria Hospital, Montreal, P.Q.

Messrs Thomas Cook & Son, Limited, recently issued an illustrated booklet on the Congress. This is published in English, French and German, and gives the general arrangements for the Congress together with an outline of the programme, and of a number of tours which may be taken following the Congress, also landing and passport arrangements.

# News Notes

## ALBERTA

CALGARY: The Calgary Association of Graduate Nurses held their annual Valentine Dance on February 12th in the Al Azhar Temple. Some 250 nurses and their friends spent a most enjoyable evening. Misses Ash, Von Gruenigan, A. Casey, acted as hostesses for the evening.

Miss Mary Watt (Calgary General Hospital), has been appointed to the Clinic in connection with the Health Department.

Miss E. Unerty (Holy Cross Hospital), has a position at the Innisfail Municipal Hospital.

Miss E. Fleming (Calgary General Hospital), is Operating Room supervisor at the Swift Current Hospital, Swift Current.

Miss Halpin (Misericordia Hospital, Edmonton), has joined the Arrowwood Hospital staff.

MEDICINE HAT: The Graduate Nurses Association held their annual meeting on February 4th in the Nurses Home of the Medicine Hat General Hospital.

Mrs. F. W. Gershaw and family have spent the winter in Ottawa.

Miss Heart has joined the staff in the Medicine Hat General Hospital.

Miss Gillcrest (Winnipeg General Hospital), is doing private duty work in Medicine Hat.

## BRITISH COLUMBIA

The results of examination for title and certificate of Registered Nurse, held recently in Vancouver and Victoria centres, only, were as follows, names given in order of merit:

(80-100%)—Miss A. Beryl McPherson, Royal Inland Hospital, Kamloops, Miss B. I. Thompson, Vancouver General Hospital; Sister M. Gabriella, St. Joseph's Hospital, Victoria; Miss C. R. Brunzell, Vancouver General Hospital.

(70-80%)—Misses J. Aske, T. A. E. Davies, I. Davies, S. E. Smith, A. E. Wakefield, O. G. Woodcock, K. M. Watson (L. J. Halliday, M. K. King, E. M. Upshall—equal), N. B. Brown, M. I. Rolston, D. Burd, E. R. Humbleton (G. Marshall, N. S. Spandier—equal), V. B. Curran, E. C. Herchner.

(60-70%)—Misses D. M. Sinclair, R. G. Smith, E. M. Ballard, M. Cooper, L. Dundas, M. M. Marlatt, Sister M. Priscilla, E. Greenwood, K. C. Postlethwaite, I. Smart, C. B. Alburt, Sister M. Dositheus, F. H. Dee (C. J. Macklin, C. M. McKay, F. M. Pelly—equal), J. C. Canniff (J. M. Joyce, J. C. Macauley—equal), E. I. Johnston, D. V. Wilkie, H. M. Randell, M. L. McIntosh, G. V. Dey, M. A. Watson, E. J. Barrat.

(50-60%)—Misses I. M. Todd, L. A. Ball, A. L. Patterson, F. M. C. Farrow, S. E.

Kerr, O. M. M. Girling, J. A. Murray, D. E. Jerome.

Passed Supplemental: E. Simpson.

Passed with Supplementals to write: I. Dynes (1), B. E. Leonard (1), C. E. McNichol (1), J. M. Hardy (1), L. A. Ball (1), H. D. Lipsey (1).

## MANITOBA

BRANDON: The Brandon Graduate Nurses Association held their monthly business meeting at the home of Miss D. Cannon. Dr. Taylor, resident physician, King George Hospital, Winnipeg, gave a splendid talk on "Communicable Diseases."

The social evening for February took the form of an enjoyable hike to the home of Mrs. L. Ferrier, Industrial School.

Miss Agnes Pearson has left the staff of the Mental Hospital, to join that of the Winnipeg General Hospital. Appreciation for her services was expressed by a boudoir lamp from the Association.

WINNIPEG GENERAL HOSPITAL: Miss Inga Johnson (1907), left recently for Hyattsville, Maryland, U.S.A.

Sympathy is extended to Miss Jessie I. Smith (1910), in the death of her niece, also, to Misses Margaret (1916), and Nora Taylor (1928), in the death of their father.

Mrs. S. Langille (Miss Cornell, 1906), opened her home early in March for a bridge in aid of the I.C.N. fund.

Mrs. George Noble (Miss Chalmers, 1920), and Miss I. Anderson (1921), have left for a trip to Montreal.

## NEW BRUNSWICK

SAINT JOHN: A very interesting address on "Endocrines, or Ductless Glands," was given by Dr. J. M. Barry, before the meeting of the Saint John Chapter of the Registered Nurses Association, held February 18th in the Nurses Home of the General Public Hospital, with Miss E. J. Mitchell, the president, in the chair. Routine business was dealt with in a short session before the lecture, and at its close, a social hour was enjoyed.

The many friends of Miss Fern Townshend (General Public Hospital, 1927), extend sympathy in the loss of her father.

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in March, 1929, were 1,150, seventeen less than previous month.

## APPOINTMENTS

Misses Myrtle Tanner, Madeleine Greer, M. McElroy, Irene Dangerfield (Ottawa Civic Hospital, 1928), to the staff of the Strathcona Hospital, Ottawa.

Miss Claire Rochez (Ottawa General Hospital, 1928), to the staff of the Strathcona Hospital.



Miss Juliette Robert (Ottawa General Hospital, 1923), as night supervisor of Ottawa General Hospital.

Miss Mavia Shingh (Ottawa General Hospital, 1927), in charge of a newly opened surgical ward in the Ottawa General Hospital.

Misses Bernice Howes, and Hazel Gates (Kingston General Hospital) to the staff, Lakeside Hospital, Cleveland.

Misses Mary Patrick, and Hannah Robbs (Kingston General Hospital), to the staff, New York City Hospital.

Miss Helen Maxwell (Kingston General Hospital, 1928), to the staff of the Smiths Falls Public Hospital.

#### DISTRICT 1

MEMORIAL HOSPITAL, ST. THOMAS: The Memorial Hospital Alumnae Association, organized to take the place of the Amasa Wood Hospital Alumnae Association, has started on what promises to be an active year's work. To secure funds two large bridge parties and a dance, attended by 350, were held. Prominent speakers have been secured for coming meetings.

SARNIA GENERAL HOSPITAL: The Alumnae Association held a very successful bridge and dance, and plan furnishing a room in the new wing from proceeds.

#### DISTRICT 2

BRANTFORD GENERAL HOSPITAL: The members of the Florence Nightingale Association were the guests at a delightful euchre and bridge given in their honour by the Nurses Alumnae and proved a particularly happy party; both associations were well represented.

WOODSTOCK GENERAL HOSPITAL: The Graduate Nurses Alumnae held a very delightful banquet, on February 14th with thirty members present. Mrs. McDiarmid, the president, acted as toast-mistress, and proposed the first toast to the King, which was responded to by the singing of the National Anthem. The toast to the training school was proposed by Mrs. Frances and responded to by Miss Huggins; to the Graduating class, proposed by Miss Davidson and responded to by Miss Cook; to the superintendent, proposed by Mrs. Shedden and responded to by Miss Sharpe. After the speeches were finished, bridge was enjoyed.

#### DISTRICT 5

HOSPITAL FOR SICK CHILDREN, TORONTO: An extremely interesting address was given on February 13th, at the Alumnae meeting by Mr. W. J. Dunlop, Director of University Extension work on, "The University as a Public Servant."

Miss Alice Grindlay (1914), has given up her position as superintendent of the Thistleton Convalescent Hospital, and is now assistant superintendent of the Hospital for Sick Children, Toronto.

Miss Hazel Elliot (1919), has accepted the position of superintendent at Thistleton.

GENERAL HOSPITAL, TORONTO: After a prolonged sick leave we are glad to announce the return of Miss Brown to the Out-Patient

Department, where she has been for some years the head nurse.

Beside the usual Dental Clinics being held every morning in the Out-Patient Department, three afternoon Clinics are now open with Miss Marguerite Malone (1926), the attending nurse.

Miss Mabel Murray (1916), has been appointed to the Social Service Department to fill the vacancy occasioned by the departure of Miss Annie Laurie Campbell, which was necessitated by the illness of her father.

A reunion of the Class of 1918 was held at the home of Miss Marnie White, on March 12th. Fifteen attended, and a very enjoyable evening was spent.

#### DISTRICT 7

The annual meeting of District No. 7 R.N.A.O., was held at the Nurses Residence, Kingston General Hospital, on February 15th, 1929, with the president, Miss Acton, in the chair.

The annual reports for the different sections were read, and the officers for the ensuing year elected. President, Miss L. D. Acton, Kingston General Hospital; First Vice-President, Miss Alice Shannette, Brockville General Hospital; Second Vice-President, Miss E. Finn, Kingston; Secretary-Treasurer, Miss Marjorie Evans, Kingston. After the business meeting, afternoon tea was served by the Kingston General Hospital staff.

Dr. Phillips Macdonnell gave an instructive address on Basal Metabolism, and Dr. Frederick Etherington an interesting talk on Egypt, which he illustrated with lantern slides.

Miss Maude Abernethy, Department Mothers' Allowances, Kingston, has been granted leave of absence, and is taking the West Indies cruise.

Miss Evelyn Freeman, Operating Room Supervisor, Kingston General Hospital, met with a serious accident, and has been confined to the hospital since January the 14th. Miss Myrtle Clarke is temporarily taking charge of the O.R. during Miss Freeman's convalescence.

#### DISTRICT 8

At the annual meeting of District No. 8, R.N.A.O., held at the Nurses Home, Ottawa Civic Hospital, on February 15th, Miss Gertrude Garvin, superintendent of nurses, Strathcona Hospital, was unanimously re-elected to the chairmanship of the District. Other officers for 1929 are: Vice-Chairman, Miss Juliette Robert; Secretary-Treasurer, Miss Grace Tanner; Councillors, Misses Forbes, Hodgkins, Lewis, Mabel Stewart, E. Pepper and D. M. Percy; Conveners of Committees: Nominating, Miss M. Stewart; Nurse Education, Miss Gertrude Bennett; Private Duty, Miss Woods; Membership, Miss Maxwell; Public Health, Miss D. M. Percy; Publications, Miss D. M. Percy.

In her report for the year, Mrs. C. L. Devitt, retiring secretary-treasurer, called attention to the increased district membership, and to the collection of over \$800.00

towards the fund being raised by the Canadian Nurses Association for the entertainment of International Congress delegates at Montreal in July.

Miss Maxwell, reporting for the Membership Committee, announced that there were 106 new members in the District, 67 of this number having been secured upon the inauguration of a membership drive in the autumn.

Reports of the other Standing Committees, given by their conveners, revealed a considerable amount of work accomplished in 1928.

A most interesting programme had been provided for the District during the year, the speakers on various occasions being, Miss Florence Emory, President of the R.N.A.O.; Miss Gertrude Bennett, Mr. John Bain, Dr. D. A. Carmichael, Dr. J. A. Amyot, Deputy Minister of Health, Dr. J. T. Shirreff.

Miss Florence Nevins represented the District at the provincial meetings. Miss Marion May had been appointed second vice-president of the R.N.A.O., and Miss Gertrude Bennett, second vice-president of the Canadian Nurses Association.

Deep regret was expressed at the loss sustained by the District in the death of Miss Janet Williamson.

The resignation of Mrs. C. L. Devitt, secretary-treasurer of the District was received with genuine reluctance. Mrs. Devitt has been untiring in the performance of her many exacting duties during the several years she has occupied this office.

Votes of thanks were extended at the close of the evening to Miss Garvin, whose whole-hearted expenditure of energy has been responsible in large degree for the past successful District year, to the retiring officers, and to Miss Gertrude Bennett, whose help and advice have been available to the officers at all times.

A delightful dance was held at the Wembley on February 22nd, under the auspices of the Ottawa Registry of Graduate Nurses. Nearly 200 guests were present. Those receiving were Miss Gertrude Bennett, Mrs. T. H. Leggatt and Mrs. H. B. Moffatt. In charge of arrangements were: Misses R. Pridmore, Ross, Greenway, Ruth Stevenson and M. Young.

**STRATHCONA HOSPITAL:** Charming in every detail was the Valentine Dance held on February 6th. The guests were received by Miss Gertrude Garvin, superintendent of nurses, and Miss Sparling, her assistant.

**OTTAWA GENERAL HOSPITAL:** With simple but impressive ceremony the new \$600,000 addition and Nurses Home was opened officially on February 12th. Dr. Rodolphe Chevrier, Dean of the Medical Board, presided. In his address Dr. Chevrier stated that the new wing answered an absolute need. In years past, patients had daily to be refused admittance because of lack of sufficient accommodation, nurses were distributed in various buildings and

sisters in charge of the wards had lacked adequate living quarters.

The building is of the very latest design in hospital architecture and equipment, and nothing has been spared to make it one of the best of its kind in Canada.

On November 17th, 1928, Hope Chabot, wife of Hon. Dr. J. L. Chabot, died after a short illness of two weeks. She was a prominent member of Ottawa's social and political world. A charming hostess, she ably did her part during election campaigns. She was president of the Alumnae Association of the Ottawa General Hospital for two years. She was also an active member of the I.O.D.E., the Women's Conservative Association and the Minto Skating Club. Her passing caused deep regret among the nurses and to a wide circle of friends.

Deep sympathy is extended to Miss Isabel McElroy, night supervisor of the Ottawa General Hospital, in the loss of her mother; also to Miss Mary Henderson, in the loss of her father.

The members of the Alumnae wish Miss Stackpole, who had the misfortune to fracture her arm recently, a speedy recovery.

#### DISTRICT 10

The regular meeting of District No. 10, R.N.A.O., was held on February 7th at the Nurses Home of the McKellar-General Hospital, Fort William. Following the transaction of routine business, plans were made for the presentation of a pageant of the History of Nursing by the members of the Association. An excellent musical programme was thoroughly enjoyed. A sketch by the senior nurses of the hospital, entitled "Making Love from the Stone Age to the Modern" was a tremendous success. The Rev. H. R. Grant, D.D., delivered a splendid and inspiring address on the subject "Enlarging your life through your Profession." Following the programme a social time was thoroughly enjoyed.

The regular monthly meeting of the McKellar-General Hospital Alumnae was held at the home of Miss Eva Hubman on February 26th, 1929, with twenty-two graduates in attendance. In addition to business of a general nature the question of re-covering the couch and cushions in the Isobelle Johnston room was discussed, and it was decided to proceed with the work forthwith. It was also decided to extend an invitation to Miss Morrison, the superintendent of the McKellar-General Hospital, to become an honorary member of the Alumnae. A very interesting paper on the benefit to children of sunshine and the ultra violet ray was read by Miss Theresa Gerry and was especially appreciated by the many young mothers present. After the meeting games and cards were enjoyed which were followed by a lunch served by the hostess, earning a most hearty vote of thanks from all present.

**QUEBEC**

**MONTREAL GENERAL HOSPITAL:** Miss J. A. Murphy, who is supervisor in the Out Patient Department has recently gone to the United States in connection with Public Health Work. She has been granted a three-months scholarship from the Rockefeller Foundation, and will visit the following places in connection with this work: Montgomery, Alabama; New York, Highland Centre, and Yale University.

Miss Flint (1929), is in charge of Ward A. Miss Rena Butler (1929), is in charge of a pavilion at Laurentian Sanatorium, St. Agathe, P.Q.

Miss Francis Reed (1912), has resigned as superintendent of the Montreal Woman's General Hospital. Miss Magdalen Houkom, of the Presbyterian Medical Centre, New York, has been appointed to take Miss Reed's place.

Miss Lockwood (1926), has returned from Saskatoon and is doing private nursing in Montreal.

Miss Seveigny (1929), has returned from Mexico City, where she has been doing private nursing for the past seven years and will continue to do private nursing in Montreal for the summer.

Miss Brewster has been spending the winter in Bermuda on account of her health.

Miss Jessie Dunlop has left for New York to do private nursing.

Miss Outterson (1915), of San Francisco, Cal., is visiting in Montreal.

Miss Agnes Bulloch and Miss K. Brock spent Easter in Bermuda.

Miss C. Watling has returned from Chatham, N.B., after three months absence, through illness.

Sympathy of the members is extended to Miss Doherty in the loss of her mother, and to Miss V. Simpson in the loss of her father.

**ROYAL VICTORIA HOSPITAL:** Miss Milla McLellan who is convalescing after a recent illness, has left to spend some time in Bermuda.

**SASKATCHEWAN**

**SASKATOON CITY HOSPITAL:** Misses Maude Williamson (1925), and V. McIvor (1927), are members of the staff at Dobb's Ferry Hospital, Dobb's Ferry, New York.

Miss Freda McKnight (1927), is a member of Drummheller Hospital staff, Drummheller, Alta.

Misses Susie Fulton and Hilda Hodgson (1928), are members of Kindersley Hospital staff, Kindersley, Sask.

Miss Elizabeth McKay (1928), is a member on the staff of Unity Hospital, Unity, Sask.

Miss Hattie Gruhke (1920), has been appointed charge of the Nurses Central Registry.

Miss Margaret Robb (1928), has accepted a position on the staff of the Elrose Hospital, Elrose, Sask.

Miss Mary Hagerman (1926), has resigned her position on the Edam Hospital staff, and is now doing private duty nursing in Saskatoon.

The sympathy of the City Hospital Alumnae is extended to Miss Annie May McFadyen (1925), in the loss of her mother, February, 1929.

Miss Laura Clarke has resigned her position as night supervisor of the Saskatoon City Hospital, succeeded by Miss Kate McLean.

**GREY NUNS HOSPITAL, REGINA:** Regular monthly meeting in February was held at Hotel Champlain in the form of a dinner.

**VICTORIAN ORDER OF NURSES**

Miss Marjorie Bell, B.Sc. (H.E.), has been appointed temporarily to the staff of Central Office. Miss Bell is a nutrition worker and will serve a number of Victorian Order districts in an advisory capacity. Miss Bell's experience, which is extensive, includes work with the Massachusetts-Halifax Health Commission and the Women's Institutes of Nova Scotia. The Victorian Order is thoroughly appreciative of their good fortune in securing the services of so able and experienced an expert in her chosen field.

Appointments: Miss Beatrice Stevenson to Barrie, Ont.

Resignations: Miss Mildred Thomas from Barrie, Ont.; Miss Edna Matheson from Carleton Place, Ont., to be married.

Miss E. Linton has returned from leave of absence to North Bay, Ont.

**C.A.M.N.S.**

**WINNIPEG:** The fifth annual meeting of the Nursing Sisters' Club of Winnipeg, was held at the headquarters of the Deer Lodge Branch, Canadian Legion, B.E.S.L., on February 20th, with the President, Miss Hudson, in the chair.

Following the president's address, the secretary's report, together with those of committees were submitted and well received. The following officers were elected for the ensuing year: President, Miss M. McGillvary; Vice-President, Miss Kathryn Ross; Secretary, Miss Mary Johnson; Treasurer, Miss Eva Letellier; Social Convener, Miss K. McLearn; Sick and Visiting Committee, Mrs. Wm. Cowan; Publicity Committee, Miss E. A. Bennett; Membership Committee, Miss Ruby Dickie; Extra Members, Miss T. O'Rourke, Miss N. Shaughnessy, Mrs. F. Grassick.

Mr. R. J. Large, president of the Deer Lodge Branch, Canadian Legion, was then introduced by the president elect. Mr. Large welcomed the members and expressed pleasure on learning that the Association had existed throughout the years following the war, remarking that it was very desirable that the old associations and comradeship of the C.A.M.C. should be preserved. He said no one knew better than the Nursing Services the real tragedies of the late war—"if the last war is forgotten, it will not be long till there will be another," continued the speaker.

Acknowledging the Nursing Sisters' Association to be a splendid one, the speaker pointed out that since the Nursing Services were indispensable during the war, and that the women of Canada took their share of the late war equally with the men of Canada, then in the days of peace he felt that they were equally as desirous of assuming their share of the problems of peace. The Nursing Services had an opportunity to do this in joining his own Association, the Canadian Legion. He extended an invitation to the Nursing Sisters' Club to join the Deer Lodge Branch, and become the "Nursing Sisters' Section" of that Branch.

Mr. Large then introduced Col. Ralph Webb, President of the Manitoba Command of the Canadian Legion. In his address he referred to the splendid type of womanhood of Canada which had gone overseas to nurse the war wounded on every battlefield. The help of the Nursing Sisters in acquiring a square deal for the disabled men, now that they were back in civil life, was just as necessary as during the war period. While the growth of the Canadian Legion, since its organization by the late Earl Haig, had been spectacular, nevertheless numbers count, said Col. Webb, and the entry of the Nursing Sisters of Manitoba into the Canadian Legion would emphasize the determination of all ex-service men and women to see that all who suffered from the effects of the war receive adequate pension.

It was unanimously decided by the members of the Nursing Sisters' Club to join the Canadian Legion.

Refreshments were served by the Deer Lodge Branch of the Canadian Legion.

A successful "bridge" and dance was given by the Nursing Sisters' Club at the Marlborough Hotel, on February 12th, when the President, Miss E. F. Hudson, received the guests, and music was provided by the Canadian Legion.

Miss G. Billyard has joined the staff at Deer Lodge Hospital.

Miss J. Roberts has left Regina for Moose Jaw, where she is acting as representative of the "Book House for Children."

Mrs. N. McCreery has been appointed to the Hospital and Beauty Parlour Department of the T. Eaton Company, at Calgary.

### BACK COPIES

Requests have been received for the following back copies: February, March, April, June, July and August, 1916; November, 1926; and March, 1927.

Any reader who is able to supply any of these copies is asked to send them to the National Office, 511 Boyd Bldg., Winnipeg, Man.

Miss Mary Wilson, Brantford General Hospital, Brantford, Ont., has notified "The Canadian Nurse" that any reader may obtain one or more of the following back copies by writing to her address, and including postage for mailing: July, August and September, 1926; January, April, May, August, September, October and November, 1927; and February, 1928.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

**BARNBY**—On February 5th, 1929, to Dr. and Mrs. T. I. Barnby (Effie Wilson, Victoria Hospital, London), a daughter.

**BOULTER**—On March 5th, at Vancouver, to Dr. and Mrs. Boulter (Constance Fisher, Toronto General Hospital, 1919), a son.

**BURLEIGH**—On December 27th, 1928, at Kingston, Ont., to Dr. and Mrs. Herbert Burleigh (Dorothy Howard, Kingston General Hospital, 1922), a daughter (Diana Howard).

**FLETCHER**—On November 2nd, 1928, to Dr. and Mrs. M. Fletcher (Emma Nightingale, Victoria Hospital, London), a daughter.

**GRIMES**—On February 9th, 1929, at Ottawa, to Mr. and Mrs. Frank Grimes (Olive Huot, Ottawa General Hospital, 1927), a son, Paul (premature).

**GUEST**—On February 8th, 1929, at Toronto, to Mr. and Mrs. Guest (Gwen Ferguson, Toronto General Hospital, 1922), a son.

**HALLETT**—On January 29th, 1929, at Toronto, Ont., to Mr. and Mrs. Edwin Hallett, of 49 Roxborough Street, Toronto (Grace Kuhring, Royal Victoria Hospital, 1923), a daughter.

**JOHNSON**—On February 3rd, 1929, at Woodstock, Ont., to Mr. and Mrs. P. Johnson (Elsie Mast, Woodstock General Hospital, 1916), a daughter.

**KIBBLER**—In February, to Mr. and Mrs. R. Kibbler (Leontine Legrand, Gray Nuns Hospital, Regina), a son.

**LITTLE**—In March, 1929, at Toronto, Ont., to Dr. and Mrs. Little (Charlotte Wallace, Hospital for Sick Children, Toronto), a son.



LOCKWOOD—On December 31st, 1928, to Dr. and Mrs. C. L. Lockwood (Phyllis Hallett, Victoria Hospital, London), a son.

LYONS—On February 10th, 1929, at Toronto, to Mr. and Mrs. Lyons (Claude Eckert, Toronto General Hospital, 1919), a son.

McKEAN—On December 29th, 1928, at Winnipeg, to Mr. and Mrs. R. W. McKean (C. Thorvaldson, Winnipeg General Hospital, 1916), a daughter.

MARKHAM—On February 17th, 1929, at Saint John, N.B., to Rev. C. J. Markham and Mrs. Markham (Georgia Moxon, General Public Hospital), a daughter (Betty Jane).

MARSDEN—On February 18th, 1929, at Fort William, Ont., to Mr. and Mrs. Marsden (Hagar Lonsdale, McKellar-General Hospital, 1916), a daughter.

MURRAY—On March 1st, 1929, at Calgary, Alta., to Mr. and Mrs. W. Murray (A. Hediger, Geneva, Switzerland), a son.

NIX—On March 6th, 1929, at Innisfail, Alta., to Dr. and Mrs. Nix (Mae Ferguson, Royal Alexandra Hospital, Edmonton, 1927), a daughter.

REDPATH—On February 18th, 1929, at Oshawa, Ont., to Mr. and Mrs. D. Redpath (Huldah Jibb, Oshawa General Hospital, 1925), a daughter.

ROBERTSON—On March 3rd, 1929, to Mr. and Mrs. Robertson (Mary Higginbottom, Toronto General Hospital, 1927), a son.

SHEPPERD—On February 10th, at Toronto, to Mr. and Mrs. Shepperd (Amy Bone, Toronto General Hospital, 1918), a son.

SINCLAIR—Recently, at St. Thomas, Ont., to Mr. and Mrs. Louis Sinclair (Anna Weed, St. Thomas Hospital, 1923), a son.

SMITH—On February 4th, 1929, at Kingston, Ont., to Mr. and Mrs. Chas. Smith (Agnes Mounteer, Kingston General Hospital, 1927), a daughter.

SULLIVAN—On December 1st, 1928, at New York City, to Mr. and Mrs. Thomas Sullivan (Hilda Jarvis, Kingston General Hospital, 1927), a son.

TEW—On January 21st, 1929, to Dr. and Mrs. W. P. Tew (Vivian Langford, Victoria Hospital, London), a son.

TIMMER—On December 18th, 1928, at Cicero, Illinois, to Dr. and Mrs. W. Irving Timmer (Patricia Hunt, Kingston General Hospital, 1921), a daughter (Willard Joan).

WARNER—On December 13th, 1928, at Kingston, Ont., to Mr. and Mrs. George Warner (Myrtle Watts, Kingston General Hospital), a son.

WHITE—On December 28th, 1928, to Mr. and Mrs. White (Irene Conlin, Toronto General Hospital, 1919), a daughter.

## MARRIAGES

CROSS—PETERS—On December 8th, 1928, at Kenora, Ont., Lucy M. Peters (Toronto General Hospital, 1924), to Joseph Cross.

ELLIOT—JARVIS—On February 22nd, 1929, at Toronto, Ont., Katherine Lillian Jarvis (McKellar-General Hospital, Fort William, Ont., 1927), to Otho C. Elliot, Toronto.

JOHNSTON—BOSS—On January 30th, 1929, at Miami, Florida, Carmen Elizabeth Boss (Victoria Hospital, London), to Robert A. Johnston, M.D., London, Ont.

MILNE—SANSOME—Recently, at Jasper, Ont., Margaret Ruth Sansome (Kingston General Hospital, 1926), to Frank V. Milne, Mountain, Ont.

PATTERSON—HALL—On January 20th, 1929, at Winnipeg, Manitoba, Evelyn E. Hall, of Sintaluta (Winnipeg General Hospital, 1912), to William Patterson, of Indian Head, Sask.

PRECIOUS—GRAHAM—On September 29th, 1928, at London, Ont., Florence Graham (Victoria Hospital, London), to Wilfred Precious, Guelph, Ont.

PUTMAN—MAXWELL—Recently, Edith Mae Maxwell (Kingston General Hospital, 1925), to Charles Austin Putman, Port Hope, Ont.

SUTHERLAND—SUTHERLAND—Recently, Queenie Sutherland (Toronto General Hospital, 1919), to Dr. Sutherland.

THERY—COOK—Recently, at Los Angeles, Calif., Leila Cook (St. Thomas Hospital, Ont., 1919), to Joseph Thery, Los Angeles.

WIGLE—READ—Recently, at London, Ont., Jane Marion Read (Woodstock General Hospital, 1922), to Jacob Wigle. At home, Kingsville, Ont.

## DEATHS

CHABOT—On November 17th, 1928, at Ottawa, Mrs. J. L. Chabot (Hope Brunet, Ottawa General Hospital, 1914).

RINN—On March 11th, 1929, at Winnipeg, suddenly, Margaret Rinn (Winnipeg General Hospital, 1912), of the D.S.C.R. ward, St. Boniface Hospital.

STEELE—Recently, at Regina, Sask., Annie M. Steele (Grey Nuns Hospital, Regina, 1915). Semi-military funeral services. Internment made in Regina cemetery, Soldiers' Plot.

STRACHAN—On February 18th, 1929, at Fort William, Ontario, Mrs. Robert Strachan (Sadie Gladstone, Toronto General Hospital and one time Head Nurse of the Gynecological Pavilion, Toronto General Hospital).

TRAIL—On December 15th, 1928, at Prince Albert, Mrs. W. M. Trail (Francis Eleanor Fortescue, Montreal General Hospital, 1897).

## TO OUR SUBSCRIBERS

Prompt attention to renewal of subscription is appreciated and assures the subscriber of uninterrupted arrival of the Journal. It is impossible to supply copies to all subscribers who renew after having allowed subscription to lapse for several months. Renew promptly and so help yourself and also the Journal, which really belongs to you as a member of the CANADIAN NURSES ASSOCIATION. By doing so, you will receive the gratitude of the Executive Committee members, who are trying to make the Journal helpful and interesting to all its readers.

### Examinations for Registration of Nurses in Nova Scotia

are to take place Wednesday and Thursday, May 15th and 16th, 1929. Candidates are required to send in their application forms, accompanied by initial registration fee of \$10.00 and diploma before April 15th, 1929, to

**L. F. FRASER, Registrar,**  
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The Frontier Nursing Service has positions for Public Health Nurses certified under a British Central Midwives' Board. Because of waiting list, applications must be received several months in advance. For further particulars, address the Director, Mrs. Mary Breckinridge, Wendover, Leslie County, Kentucky.

## THE CANADIAN NURSE

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## REGISTRATION of NURSES

PROVINCE OF ONTARIO

### EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held in May.

Application forms, information regarding subjects of examination, and general information relating thereto, may be had upon written application to Miss A. M. Munn, Reg. N., Parliament Buildings, Toronto. No candidate will be considered for examination unless the complete application form, accompanied by the examination fee of \$5.00, is received by the Inspector, before May 10th, 1929.

Signed:

A. M. MUNN, Reg. N.,  
Inspector of Training Schools.

## *The Victorian Order of Nurses for Canada*

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## *April Musings*

"I'm tired. . . . I need a new hat. . . . If that patient's bell rings again I'll slay her. . . . My feet hurt. . . . I like Mary's new shoes, but when do I ever get any time to buy things? . . . There's a fly—I suppose they're beginning now. . . . Almost time for diets. . . . What a life! I wish I could have a holiday, a real one; right away from four white walls, from self-important doctors, from sick people, from rules, regulations, meals in the dining-room, parties in the home; right away from everyone and everything. . . . I think I'll go to Europe on one of those tours. All the nurses who have gone on the ALL-CANADIAN PARTIES have had a wonderful time. I think I'll go too. I just have time to drop a line to MISS HESSON, and get her to hold some space for me. She will tuck me in somewhere even if it is late."

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# The Canadian Nurse

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## MAY 1929

### CONTENTS

	PAGE
THE CHALLENGE OF THE FUTURE - - - Florence H. M. Emory	227
HOUSEWIVES' NEUROSIS - - - - - Mary Chadwick	230
TREATMENT FOR ELECTRIC SHOCK - - - - - P. Lumly	232
INTERNATIONAL COUNCIL OF NURSES, GRAND COUNCIL - - - -	234
DEPARTMENT OF NURSING EDUCATION:	
STAFF EDUCATION - - - Eileen C. Flanagan and Kathleen B. Hill	241
MENTAL HYGIENE AND NURSING - - - - Dr. G. A. Davidson	243
SUMMER RELIEF NURSES - - - - Pearl L. Morrison	245
HISTORY OF NURSING SOCIETY, MCGILL UNIVERSITY Ursula Whitehead	247
DEPARTMENT OF PRIVATE DUTY NURSING:	
AN INTERESTING CASE OF DIPHTHERIA - - - Dr. S. F. MacPherson	248
MY MOST INTERESTING CASE - - - - Maureen Carley	249
DEPARTMENT OF PUBLIC HEALTH NURSING:	
A SYSTEM OF SCHOOL MEDICAL INSPECTION - - - Dr. F. S. Burke	251
CONGRESS, INTERNATIONAL COUNCIL OF NURSES - - - - -	256
ANNUAL REPORTS, PROVINCIAL MEETINGS - - - - -	257
NEWS NOTES - - - - -	259
OFFICIAL DIRECTORY - - - - -	267

# The Challenge of the Future

By FLORENCE H. M. EMORY, Department of Nursing, University of Toronto.

"The hours should be instructed by the ages, and the ages explained by the hours," affirms Emerson in one of his inimitable essays. There is a grave danger that, in the bustle of the work-a-day world we shall evaluate the present and forecast the future without due regard for the habits of thought and modes of action which have conditioned present-day practice and will necessarily influence future attainment. Preoccupied with the daily task: its irritations and failures, which one of us does not focus attention upon the limitations of the present rather than through a study of the evolution of our profession, see reflected in the present a marked degree of accomplishment and thereby gather inspiration for future achievement.

In an exhaustive publication, "Four Centuries of Medical History in Canada," Dr. Heagerty, writing of the growth of the medical profession in Ontario, relates that in the year 1815 there were between thirty-five and forty qualified practitioners in the province. In 1819, John Gilchrist, of Hamilton, was granted a certificate to practise physic, midwifery and surgery. That versatile gentleman also conducted a saw mill and grist mill, and functioned as justice of the peace. Of physicians in general it is written "they were paid seldom in the coin of the realm, most often the best the early settler had to offer was his heartfelt thanks." And what of the sister profession, nursing? We recollect that at the second annual meeting of this association in St. Catharines, Dr. Greenwood told of the establishment of the first Canadian hospital school for nurses in that city in 1874. For encouragement hear an extract from an address

delivered by Dr. F. J. Shepherd in 1905 to a group of graduates of the Montreal General Hospital, when, notwithstanding the enviable traditions of that institution, he told of the existence of well-nigh incredible conditions in former days. "The wards were small and rather untidy. The nurses were good creatures, and motherly souls some—all uneducated. Many looked upon the wine (or brandy) when it was red. In those days it was with the greatest difficulty that patients could be induced to go into a hospital. It was the popular belief that if they went they would not come out alive. Armies of rats disported themselves about the wards. Nothing was known of sepsis or antisepsis. Surgeons operated with dirty instruments and septic hands: wore coats which had been baptized in the blood of victims."

In contrast to the dark picture which portrays, in part, conditions of the last century, present-day activities in Ontario reflect progress. To enumerate some of the more obvious: registration is an accomplished fact, with eleven thousand nurse registrants since its inception and six thousand last year; there are approximately one hundred hospital schools for nurses, with a duly appointed inspector functioning under the provincial department of health, and an active advisory nursing council; during 1928 over one thousand graduates entered the profession; special preparation is available in two universities for those interested in either one of two branches of nursing, hospital teaching and administration, and public health nursing; supporting and promoting professional development are more than sixty alumnae associations, and a provincial organization established in 1904, and reorganized in 1925—the Registered Nurses Association of Ontario.

(Presidential Address, Fourth Annual Meeting, Registered Nurses' Association of Ontario, April, 1929.)

From such evidence the postulate is deduced that nursing is evolving from that which we hesitate to recall to that which we would have it become. Further, in that evolution professional organisation must needs continue to exert a strong influence. Virility and persistency have characterized the efforts of the provincial association during the past year. With each of the nine districts showing a substantial increase, the organisation boasts of more than sixteen hundred members. In terms of potential membership, that is not enough. A minimum of two thousand is our objective. Speaking of objectives, an outstanding business man was heard to say recently that the only thing to do with an objective is to exceed it so far that it cannot be seen. That precept has been followed in the raising of our allocation for the hospitality fund of the International Council of Nurses.

To return to our thesis, that is, that nursing is evolving, and that in that evolution professional organization will continue to exert a potent influence. I submit the future challenges us to an enrichment of professional life. The organised effort of any group falls short of its privilege if it fails to cultivate a desire for knowledge. There is an increasing awareness of the wisdom of Plato's words, "Education is a life-long business." Learning may take place not only in elementary and high school life, and within university walls, but also in the pursuit of one's vocation—in the daily walk of life. A friend said of Lincoln, that he was always a learner. In that respect he was the most notable man he had known. I take it that an important function of professional organisation and a criterion by which attainment may be judged is the degree of assistance given to a cultivation of the receptive mind: the mind which is eager to grasp new thought if such have scientific basis. There are well-known avenues which through intensive study may come, such as the post-graduate and refresher course, but granted these

may or not have been utilised, the professional organisation may in addition further post-graduate education through an encouragement of individual study of daily contacts whether in the field of sick or health nursing. An attitude of mind should be fostered which will lead each member to realize that she may contribute to the sum total of scientific knowledge, that she, through the laboratory of daily experience, may make observations which will materially aid in curative and preventive nursing. The professional group may help to instil in its young members that which will compel them to seek further development and at the same time offer opportunities for self-improvement. Nor should individual or group vision be limited to the horizon of professional life. The ultimate goal is the living of a life, rich in usefulness, helpful in spirit, and much may be done to create in younger and older a reasoned and satisfying philosophy of life itself. Those most keenly aware of the necessity for organised effort know that survival is conditioned by a constant reinforcement of recent graduates. There is recognition of dependence upon young life: young life possessing an urge which insists upon growth; young life which is willing to forgo much in order that growth may be experienced. In turn we should be prepared to offer opportunities for the enrichment of such life. The organized group is privileged to act as an incentive—a stimulant, encouraging those with ability to develop their powers. Existing opportunities are numerous and diverse. Shall we hope that added to these: the reading of books and journals, and attendance at conventions with papers, round-table conferences, exhibits and demonstrations, the future may witness a broadening of international viewpoint through interchange of experience in other countries.

The challenge of the future includes not only the enrichment of professional life but a progressive community nursing service. The two are



inter-related. When the accomplishment of science during the last fifty years is contemplated may we not visualise a future community where through additional knowledge and co-operative effort, death and illness have been further reduced and the life span of the average individual further increased. Sir George Newman has stated that an infant born in England in 1926 had a life expectancy twelve years greater than of a child born one hundred years ago. In such endeavour each branch of our profession may share. Let none think that the public health nurse functions alone as a health worker. Admittedly she is a specialist in that field, but the hospital nurse and the private duty nurse alike may be effective agents in increasing individual and family health. Is it Utopian to suggest that in future centralized machinery will be provided through which all community nursing services may be directed whether curative or preventive in character? Should such come to pass, professional organization through individual and group effort should safeguard and enhance the effectiveness of such a project.

Though manifold and exacting the demands made upon the organized professional group, the challenge of the future, if accepted, may be met through conviction, loyalty and endeavour. These are the *sine qua non*

of professional growth: conviction regarding the value of organized effort, loyalty to its traditions and aspirations and endeavour in the realization of its objectives. That experience should be shared by the majority rather than the minority. The most effective remedy for discouragement is belief in the future, and one of the potent factors in moulding the future of nursing is organized group effort revealing as it does the spirit and ideals of the profession. Sitting in the Lady Chapel of the Liverpool Cathedral my attention was drawn to stained glass windows dedicated to those who had done honour to womanhood through rendering a signal service to humanity — among them Florence Nightingale and Agnes Jones. My thought instinctively turned from those who had given so much, to the profession of today. I pondered—did the torch, lighted with a revered tenacity of purpose and breadth of understanding, burn as brightly in the hands of their privileged successors—did the spirit which prompted the re-organisation of nursing and the establishment of district nursing continue to permeate the profession today? If with daring and devotion the challenge of the future be accepted, professional organisation may go far in perpetuating the true spirit of nursing. In the last analysis with that rests future safety.

Who would true valour see,  
Let him come hither;  
One here will constant be,  
Come wind come weather.  
There's no discouragement  
Shall make him once relent  
His first avowed intent,  
To be a pilgrim.

Who so beset him round,  
With dismal stories  
Do but themselves confound—  
His strength the more is.  
No lion can him fright,  
He'll with a giant fight  
But he will have a right  
To be a pilgrim.

Hobgoblin nor foul fiend  
Can daunt his spirit:  
He knows he at the end  
Shall life inherit.  
Then fancies fly away,  
He'll fear not what men say,  
He'll labour night and day,  
To be a pilgrim.

## *Housewives' Neurosis*

By MARY CHADWICK, S.R.N., F.B.C.N., London, England

At first glance it would seem impossible that the practice of the housewifely art, the absence of which is now so frequently deplored, could ever take on a form that could be both inconvenient and dangerous. That might be the opinion of one who has never come in close contact with one in whom the virtues of cleanliness and tidiness have run riot, or who has raised her house and domestic duties into the position of a tyrannical god, who is only to be appeased by the sacrifice of the happiness of all who come within its walls.

Those who know by experience to what degree this scourge can be raised, will readily endorse the statements that follow. Here we have the woman anxious to keep her house spotless from floor to ceiling, to rub and polish, scour and sweep from morning to night, or to compel others to do so at her bidding. Admirable though this impulse may be when kept within bounds, it is easy to realise that for the other inmates of the house constantly to be kept in a state of tension resembling that which is typical of spring cleaning, becomes in time a menace to the nervous health of, not only the woman herself but also her husband and children.

One might hope that in time the zeal might flag, and the energy be spent, when physical fatigue sets in as the inevitable result of these herculean labours. Still experience teaches that there is very little use in waiting for the consummation of this hope. The housewife with this form of neurosis seems endowed with inexhaustible recuperative power, and even when showing the usual signs of human tiredness, presses on to finish the self-appointed tasks or to spur herself on to fresh endeavour, denying, even to herself, the fact that she is subject to the common frailties of life, and may become overtired and therefore cross.

She will require that others who compose the household must also take their part in the endeavour. Minute instructions will be given to the husband to be careful to wipe his boots thoroughly before coming into the house. She may also find some excuse which enables her to stand by the door in order to watch if her wishes are carried out, her fear being that dust from the street will enter and contaminate the cleanliness she has been working so hard to establish. The children will scarcely be allowed to play lest they may disarrange the order of her rooms, or raise dust from secret lurking places, and hardly before the visitor's back is turned she is shaking out the cushions they have pressed out of shape.

Everyone is given an exaggerated idea of the importance of cleanliness, and dirt is represented as an unspeakable horror. Toys must not be bought in the street in case their vendors have kept them in dirty houses. It is impossible to eat fruit until it has been washed or cooked. The idea of contamination quickly spreads from one object to another, when anything called "dirty" is in question. When this occurs, the entire ritual of cleansing must be started over again from the beginning and be carried out in every detail.

Most miserable of all is the woman herself. Work how she may she cannot be satisfied that the cleanliness and polish she strives for has been realized. She will worry what may be the effect of her negligence upon her dear ones, should she leave one corner unscoured or fail to wipe off one stain that has sullied the purity of her paintwork. Fret and worry, worry and fret will sooner or later undermine her health as much as the physical strain of the over-work which she imposes upon herself. Should she be hindered in her task of cleaning,

she may work herself into a state bordering on panic, accuse herself of injuring her household and suffer agonies of remorse concerning what may be the results of her neglect upon herself and others. When the children come back from school they are also fussed and worried continually, and her husband's evenings are spoilt because, instead of sitting down to rest and enjoy herself, or share some recreation with him, she still toils on unsparingly.

She says this incessant work and drudgery is absolutely essential to protect the health and welfare of her family and that only by this means can domestic hygiene be maintained. Of course we know that sooner or later her condition will need the doctor's help, but this is a view that she herself would deny. An onlooker will soon realize that more is at stake as the result of these monumental efforts than the mere outward cleanliness of the home. Her self-reproaches, the far-reaching fears of contamination that may be spread by dust or her negligence will give us the clue that these actual ideas are really standing for others which are of still greater importance to her mind, although consciously she has not yet grasped the connection between them.

We shall find two main roots to the trouble, first that in her childhood, she was probably subjected to most rigorous training in cleanliness. It was preached to her as a moral obligation. Cleanliness was not only "next to godliness" but on an equality, even if not of more importance, and so the idea of guilt was closely attached to the outward uncleanness of the person or of things. The house often holds the allegorical meaning of the woman herself, and so to the idea of the unclean house, a symbolic significance of moral impurity becomes attached. Her anxiety over the cleanliness of her house will re-echo injunctions from childhood about personal ablutions, and the excretions of waste products from the body, just as rooms must be left spotless and every corner cleared of dust and rubbish. Any refuse or dirt may con-

taminate other things and spread disease to the inmates of the house. The idea is the descendant of instructions concerning daily evacuation of the bowels also, accompanied by threats of warning of illness as the consequence of disregard of precautions.

It is easy to forget these strict injunctions in childhood and the impression they made upon us in those days, just as now they still exist without any memory being able to account for the strange obsessions, which causes so much worry and unhappiness. Far from uncommon is it also to find these persons constantly reproaching themselves about spiritual uncleanness, and they will suffer deeply under the delusion of a burden of sin. In the symbolic action of cleaning the house, they not only carry out the idea of cleansing the house (her body), an attempt is made at the same time to cleanse the conscience, which seems besmirched in some way, which reminds us of Lady Macbeth, who constantly washed her hands in her sleep-walking dreams, with the intention that she might thereby cleanse her soul or mind from the guilty stains of blood-shed.

The two ideas of infant naughtiness connected with being dirty, and guilt attached to moral uncleanness, have in this way produced the symptom which is most in evidence in Housewives' Neurosis. The guilt and the moral uncleanness may in a large number of cases be entirely imaginary, that is of no account, but even though the victim of this trouble may be persuaded for a time that her fears are groundless, they will quickly return once more upon the least provocation, even should they have disappeared for a time when they were set at rest.

Cure of this distressing condition would only take place, when side by side with the present-day symptoms could be placed the pre-disposing causes:—the childish phantasies that went to its construction, and the special incidents of early experience which resulted in this trouble taking precisely the form which we see.

## *Treatment for Electric Shock*

By P. LUMLY, Sarnia General Hospital, Sarnia, Ontario.

Electric accidents from a medical and nursing standpoint may be subdivided as follows:

- (1) Electric shock.
- (2) Electric burn.
- (3) Associated traumatic conditions such as, wounds, fractures and other types of injuries.
- (4) Complications of electrical injury such as paralysis, organic and functional.
- (5) Sequelae of electric injuries; scars, deformities, psychosis, neurosis, neurasthenia and melancholia.
- (6) Death.

**Electrical accident** is caused by the individual coming in direct or indirect contact with a conductor of electricity. The shock may be accompanied with unconsciousness of varying duration, or death may result.

Effects or conditions are: Rigidity of muscles, more or less generalized; interference with or paralysis of respiratory system; excitation of central nervous system; spasms of blood vessels with congestion and edema.

The exact mechanism of death from electrical shock is uncertain, but at present it is thought that death may be due to either a paralysis of the respiratory or vasomotor centres, or to ventricular fibrillation.

From the nursing standpoint we are not so much interested in the cause of death as the effects of the remedial measures to help prevent death. This means action, and that must be immediate: Quickly release the victim from the current, being careful to avoid receiving a shock. Use any dry non-conductor (rubber gloves, clothing, wood, rope, etc.) to remove either the victim or the conductor. Beware of using metal or any moist material, endeavour to free one hand at a time; if necessary shut off the current. If the victim is on a pole, see that it is secure to avoid further injury by falling. On the individual being removed from

contact with the current, artificial respiration is at once instituted, the Schaefer or Prone Pressure method being used:

Place the patient face downward, one elbow flexed, forehead resting on wrist, face turned opposite flexed elbow. Loosen neck and wrist bands and clear air passages, if jaws are relaxed. Straddle the patient, kneel with the knees just below the hip pockets, place the palms of the hands on the small of the back with the fingers resting on the ribs. With arms held straight, swing forward slowly so that weight of your body is brought to bear on the subject. Two or three seconds is the time this should take. No violence should be used as internal organs may be injured. If another person is present he can clear the air passages, loosen neck and waist bands, but no delay must be made in commencing artificial respiration.

When notification is received that a patient suffering from electric shock is on his way to the hospital, a large airy room, if possible with two windows, is prepared at once.

Place the bed near a window. Arrange a fracture board (not in the usual way for a fracture) but across the centre of the bed. This serves a twofold purpose. First as a sufficient support for the victim's abdomen and chest, and second, an easy method for workers, who, without one intermittent stroke, continue their work faithfully and skillfully until rigor mortis has been pronounced, or the patient shows signs of restoration. Protect the mattress and make the lower part of the bed as for an ether bed, but do not put any top clothing in place. On a radiator or back of a chair have old blankets folded.

On the bedside table have two emesis basins, ether wipes, gauze, sponges, cotton swabs, mouth gag,



tongue forceps, needle holder, curved needle with strong silk and a strip of adhesive.

Stimulants—Caffeine, Soda-Benzoyate Ampule, and a hypodermic is prepared with the same unless otherwise ordered.

Eight hot water bottles at correct temperature are filled, covered, and placed between the blankets.

The oxygen tank is in readiness to turn on, and be sure there is an adequate supply on hand.

On the arrival of the ambulance the patient is placed on the bed face down, resting on flexed forearm, face turned away from bend in elbow, with as little interference with the artificial respiration as possible. Cover the upper and lower part of the body with blankets placed crosswise. Hot water bottles are to be immediately placed to axillae, chest, limbs and feet.

*Remember no attempt must be made to undress the patient.*

Oxygen must be given continuously. Authorities say pulmotors are contraindicated and some say stimulation is of no avail. However, observations do not lead us to believe it to be injurious.

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Visitors to the Congress of the International Council of Nurses, who are arranging to travel through Canada, are cordially invited to Manitoba. Winnipeg is the capital of Manitoba, the third largest city in Canada, and is the Gateway of the Canadian West.

Nurses who wish to take a holiday where everything is different, will enjoy a trip up Lake Winnipeg to historic Norway House, or a trip to the North via the new Hudson Bay Railway (which will be ready for passenger service by July).

Nurses who wish to visit institutions and organizations in order to become acquainted with the nursing services of the province, may have arrangements made for this purpose. Information can be obtained from the Convener, Hospitality Committee, Manitoba Association of Registered Nurses, 753 Wolseley Ave., Winnipeg, Manitoba.

Do not interfere in any way with those who are giving artificial respiration. The nurse's duty is to keep the mouth and throat free from mucus and continue oxygen, the doctor may secure the tongue with a suture if necessary.

See that hot water bottles are replenished by replacing one when one is removed, and the hypodermic always in readiness to administer.

Do not grow weary in well doing until the doctor has pronounced rigor mortis present.

Our first case, May, 1927, had artificial respiration administered continuously for **eight** hours, and made a good recovery.

In a second case, after **three** hours work rigor mortis was present, while in a third case artificial respiration was continued for **five** hours and the patient fully recovered.

Burns are treated after respiration has been fully established by the order of the physician. The patient may then be undressed, bathed and general care given. Convalescence depends on the systemic effect of the shock, and will be treated accordingly by the physician.

The International Catholic Guild of Nurses will hold its fifth annual convention in Montreal, July 5-8. Invitations have been sent to groups of nurses in Europe to attend the convention and the programme will be both in English and French. Arrangements are being made for the holding of numerous round table discussions. In the United States special excursions will be conducted from various sections to Montreal, and a special train will be made up in Chicago to carry nurses from the west and middle west, who will assemble there, on a tour which will include interesting features of the United States and Canada, allowing a week at Montreal to attend the Guild's Convention and the Congress of the International Council of Nurses. The headquarters of the International Catholic Guild of Nurses are at the Auditorium Hotel, Suite 142, Chicago, Illinois.

## International Council of Nurses

### Grand Council

Members of the Grand Council, International Council of Nurses, will meet in Montreal on July 5th, 6th, and 7th, 1929. These meetings will be held at the Montreal High School, 3449 University Street.

The Grand Council consists of the Honorary Presidents; the Officers; the National Representatives (i.e., the Presidents of national organizations of nurses which are active members of the International Council of Nurses); and four accredited delegates in addition to the President from each active member of the Council. The Grand Council represents the voting body of each Congress.

It was planned to publish in this issue a short biographical note on each member of the Grand Council. Unfortunately replies have not been received to a number of the requests made some time ago to secretaries of national organizations for some information relative to their representatives to the Congress.

Notes as received to date are being published forthwith, and it is hoped the other countries may be heard from before the June number goes to press.

### Honorary Presidents:

*Mrs. Bedford Fenwick*, elected an honorary president in Berlin, June, 1904. (See "The Canadian Nurse," March, 1929.)

*Miss Annie W. Goodrich*, elected an honorary president of the Council in Helsingfors, July, 1925, was president from 1912-1915. Her career as a nurse was begun in the New York Hospital, from which she graduated in 1893. Her professional career has been phenomenal in variety of experience . . . a quality of pioneer enthusiasm, and a capacity for hard work in whatsoever field of endeavour claimed her.

Miss Goodrich has demonstrated an unusual ability to adapt teaching to the realities of life, while cherishing the highest academic aspirations. Thirty years in action, with a record of breadth, precision and instinctive unselfishness gives assurance to whatever enterprise Miss Goodrich may venture.

Miss Goodrich has been superintendent of nursing at several hospitals; i.e., New York Postgraduate, St. Luke's, New York, and Bellevue and Allied Hospitals; also director of nurses, Henry Street Settlement; lecturer and assistant professor, Department

of Nursing and Health, Teachers' College, Columbia University; dean of the Army School of Nursing; and since 1923 dean of Yale School of Nursing. In nurses organizations, Miss Goodrich has served as president of the National League of Nursing Education, the American Federation of Nurses, and the American Nurses Association, as well as of the International Council of Nurses. ("The I.C.N.," April, 1926.)

*Mrs. Henry Tscherning*, president of the Council, 1915-22, was elected honorary president in Copenhagen, May, 1922.

A few months after the foundation of the Danish Council of Nurses in 1899, Mrs. Tscherning was elected its president, a position which is still honourably held by her. By means of her tenacity of purpose, her unique gifts of administration, her facility of co-operation with all whom she has to deal, and thanks also to the very advanced social legislation of the country, the Council has, during her presidency, developed into the best organized national nursing body in the world. It includes, literally, every trained nurse in Denmark, and its provisions for sickness, disablement and old age are unsurpassed. It exercises a satisfactory control over its members, numbering more than 5,000, and this is probably the main reason why the government has not yet found it necessary to interfere in any way by the passing of a Nursing Act.

Mrs. Tscherning has always been greatly interested in nursing movements in other countries. She was the means—in spite of some opposition—of setting up a Constitution for the Danish Council of Nurses in conformity with the requirements of the International Council, with the result that the affiliation of the former took place at the Congress in London in 1909. ("The I.C.N.," April, 1926.)

(Mrs. Tscherning resigned in 1927—Ed.)

### National Representatives and Accredited Delegates:

#### CHINA

*Miss Lillian Wu*, president, Nurses Association of China, is from Foochow. After completing her training in China, she graduated from the Johns Hopkins School of Nursing in Baltimore, U.S.A., followed by post graduate work at Boston and New York. She is the first Chinese nurse to become superintendent of a Registered School of Nursing entirely under Chinese management. She is superintendent of nurses of the Red Cross General Hall of Healing at Shanghai. Miss Wu represents the grace and charm of the continent of Asia where nursing is still in its infancy. (From—"A Joy Ride through China.")

*Miss Shih Hsi En*, the general secretary of the Nurses Association of China, is a scholar of unusual ability, speaking English, Mandarin and several dialects fluently.

She completed her professional training in the Sleeper Davis Hospital, at Peking in 1917, and secured "Honours" in the National Examinations. In 1918 she received the Diploma in Midwifery, and for the next two years supervised in the hospital. Then for three years she studied in the United States, familiarizing herself with all branches of nursing. On her return she became assistant, and is now superintendent of nurses in the Sleeper Davis Hospital.

She has served on many committees of the Nurses Association of China, and has done public health, war, school, private duty and institutional nursing in addition to being president of the Peking Auxiliary. She is quoted as being, "strong physically, mentally and withal a charming winsome woman."

*Miss Agnes Chan*, vice-chairman of the Educational Committee of the Nurses Association of China, and the superintendent of nurses of the Wesleyan Hospital, Fatshan, Kwangtung, China, is a Canton girl. She trained in Toronto. She has a paper on Private Duty Nursing in Asia for the Congress.

*Miss Ruth Ingram*, was born in China, as her father was one of the early missionary doctors there. She received her training in the United States, and is now superintendent of nurses of the Peking Union Medical College Hospital, Peiping, Hopei, China.

*Mr. Kuo Jung Hsun*, is general supervisor of the operating rooms and surgical work of the Peking Union Medical College, Peiping, Hopei, China. He is a graduate of that School and is also chairman of the Headquarters Committee of the Nurses Association of China. Mr. Kuo has charge of one of the Round Tables on Staff Work at the Congress.

## CUBA

*Senorita Martina Guevara*, president of the National Association of Nurses, Cuba, on graduating from the training school of nurses, at "Mercedes" Hospital, Havana, became head nurse of the gynecology ward and operating room, and later, superintendent of nurses. In 1921, she organized visiting nurses, in the Infant Hygiene Section of the Department of Health, throughout the whole country. The following year, she undertook a special course of practical work at the Presbyterian Hospital, New York, in addition to a teacher's course at Columbia.

Upon her return, she was appointed instructress of Practical Work for three training schools in Havana. Last year, she was awarded a gold medal by the Cuban Government for twenty-five years of continuous service.

She has taken a great interest in association work, being one of the organizers of the National Nurses Association of Cuba, and acting secretary and treasurer for a number of years. In 1928, she was made an Honorary Member in the Order of Merit of the Red Cross of Cuba.

*Senorita Hortensia Perez Llerena*, after graduation from "Hospital No. 1," Havana, Cuba, accepted an appointment on the staff, which led to the position of night supervisor. Two years later she was appointed superintendent of nurses in the Santiago de Cuba Hospital, in the Province of Oriente, from which she later resigned to accept a similar position in the Camaguey Province Hospital.

Her other activities include the position of: Commissioner in the Office of "Infantile Service," in the Department of Health, Assistant Chief, and finally General Supervisor.

Her services have been recognized by the Supreme Council of the National Red Cross who have made her an Honorary Member in the Order of Merit of the Red Cross of Cuba.

## DENMARK

*Miss Cornelia Petersen*, is the representative of the Danish Council of Nurses, and is acting as proxy for the president, Miss Charlotte Munk, who is prevented from attending the Congress due to ill health.

After having finished her training in 1905, Miss Cornelia Petersen occupied herself with visiting nursing until she left for England in 1910, from where she only returned shortly after the outbreak of the world war. From August 1915 to December 1919 she held a supervisory position in one of the departments of the newly erected State Mental Hospital of Nykobing, Sj., since which time she has been the Director of the School of Nursing of the Municipal Hospital in Aarhus.

Miss Petersen is very interested in her profession and its progress. Since 1920 she has been a member of the Executive Committee of the Danish Council of Nurses, and the most active president of the Provincial Nurses Association of Denmark (an affiliated organization of the Council). She is also a member of the Eligibility Committee of the Council. The first book in Danish on the History of Nursing and published by the Council in 1928 was written by Miss Petersen. She acted as a delegate of the Council at the meetings held in Copenhagen by the International Council of Nurses in 1922 and 1923, as well as at the Congress in 1925 in Helsingfors.

*Miss Petrea Sorensen*, graduated from Bispebjerg Hospital, Copenhagen, Denmark, five years ago.

Since 1925, she has studied in the Illinois Training School for Nurses, the Sloane Maternity Hospital, New York, and Bloomington Hospital, White Plains.

Last year she registered in New York State, and recently received a Bachelor of Science degree from Teachers' College, Columbia University.

*Miss Clara Feldthaus*, trained for three years in medical and surgical nursing at the Kommunchospitalet, Copenhagen (Municipal Hospital, 1,000 beds), from where she graduated in 1920. She then attended post-graduate courses in obstetrical, mental and

contagious diseases' nursing, and since 1925 she has been in charge of a surgical ward for men at the Municipal Hospital, Copenhagen. Miss Feldthaus is now having sixteen months leave of absence in order that she may study nursing in the United States.

Miss Petrea K. Andersen, graduated in 1924 from the Svenborg County Hospital, and later spent six months in a post-graduate course at the States Mental Hospital, and two months in a similar course at the States Maternity Hospital. For the past three years she has been a member of the nursing staff at the Municipal Hospital, Copenhagen, and is at present on leave of absence, the same as Miss Feldthaus, for study of nursing in the United States.

Miss Kirsten Becker, graduate of Bispebjerg Hospital, Copenhagen, will also attend the Congress as a delegate. At time of going to press no notes have been received from Miss Becker.

#### ENGLAND

While no biographical notes have been received from England—some information was obtained from "The British Journal of Nursing," and the 1928 edition of "Who's Who."—(Editor.)

Miss Margaret Breay, after graduating from the newly organized St. Bartholomew's Nursing School under Miss Ethel Manson (Mrs. Bedford Fenwick), was appointed sister at the Metropolitan Hospital, London. Following this she took her course in obstetrics at St. John's Hospital, obtaining the diploma of the London Obstetrical Society, remaining there as superintendent of the Training School. A couple of years later she returned to the Metropolitan Hospital as matron.

In response to an appeal from Zanzibar, Miss Breay volunteered for work for the Universities' Mission to Central Africa, and later accepted the position of matron at a new hospital built by the Mission in Zanzibar.

A year and a half later, as a result of ill-health, she was compelled to return home, to be connected with Mrs. Fenwick in the organization work of nurses, especially as assistant-editor of *The British Journal of Nursing*.

In addition to various other positions, Miss Breay has acted as honorary secretary of the Matrons' Council of Great Britain and Ireland, of the Registered Nurses Parliamentary Council, of the Nursing Section of the International Council of Women, and as honorary treasurer of the National Council of Nurses of Great Britain, and of the International Council of Nurses. In 1925, she was elected an honorary member of the Council.

Mrs. Lancelot Andrews, trained and certificated at St. Bartholomew's Hospital, London, where she was Gold Medallist of her year, held successively the position of night superintendent, ward sister, temporary as-

sistant matron and home sister in her Training School.

After the death of her husband, she was appointed Inspector under the Ministry of Health, a position recently resigned.

During 1917-1918, she helped in the organization of Queen Mary's Women's Army Auxiliary Corps. She was the first recruiting controller, organizing the system throughout the country.

A Foundation Fellow of the British College of Nurses, Mrs. Andrews has been appointed to a seat in the Council. In addition to being a distinguished speaker, "she brings to her position an enthusiasm rooted in knowledge, capacity and a strong sense of duty, and a winning personality."

Miss Helen Lucy Pearce, trained and certificated at St. Bartholomew's Hospital, London, subsequently held the position of assistant superintendent at the Lambeth Infirmary, matron at the North Staffordshire Infirmary, and at the Great Northern Hospital, London; but her life's work has been superintending the school nurses under the London County Council.

From its inception she has attended the meetings of the International Council of Nurses acting as delegate of the National Council of Nurses of Great Britain, of which she is honorary secretary. She is also vice-chairman of the Royal British Nurses Association, and president of the Matrons' Council of Great Britain and Ireland, and of the London County Council School Nurses Social Union. She is a Foundation Fellow of the British College of Nurses and has been appointed a vice-president by the Trustees.

Miss Rachel Cox-Davies, C.B.E., R.R.C. (with Bar), is a graduate of St. Bartholomew's Hospital, London, and had war service in the South African and Great Wars. Miss Cox-Davies has been matron of the Royal Free Hospital, London, and of Queen Alexandra's Army Nursing Board. She has served as a member of the General Nursing Council of England and Wales, and of the Council of the College of Nursing, of which she is now president. Miss Cox-Davies has been a Guardian of St. Pancras District since 1923.

#### HOLLAND

Miss Meta Kehrér, president of Nosokomos, trained in the Wilhelmina Gasthuis, Amsterdam. For some time after graduation she was attached to the operating room and the obstetrical ward of the hospital. Then followed a year as an anesthetist in Het Burger-Ziekenhuis, a private hospital. From 1917-1920, she undertook hospital social work which later included work with the public health service of Amsterdam. From 1923 on, she became inspector in the Juvenile Court.

Since the beginning of her career, Miss Kehrér has been a prominent member of Nosokomos. She has been a member of the editorial board of the magazine, and a member of the executive. In 1925, she



became president. Recently she was elected to the executive board of the National Bond van Verplegenden.

*Miss S. A. Wesseling*, previous to her nursing career, was engaged in social service work. She received her training at the Wilhelmina Gasthuis in Amsterdam, obtaining in 1913, the diploma for general nursing, and in 1915, that for maternity nursing. Since 1916, she has been engaged in private duty nursing.

*Miss A. Terpatra*, received her diploma from the Mental Hospital, in Zutphen, in 1911. In 1912, she began her training at the Wilhelmina Gasthuis in Amsterdam. In 1914, she received her diploma for general nursing, and in 1916, that for maternity nursing. Since then she has been engaged as a private nurse.

*Miss M. Serton*, is a graduate of the General Hospital and of the Surgical and Maternity Clinic at Utrecht. She received the diplomas for general nursing, district nursing (Green Cross Diploma), tuberculosis nursing and her certificate as midwife of the Central Midwives Board, England. Following a year's practice in the General Lying-in Hospital, London, and after one year spent in private nursing, she became district nurse at "The Green Cross," Utrecht, in 1926.

## INDIA

*Miss Catherine Frances Slater*, who was trained at Guy's Hospital, London, and the Rotunda Hospital, Dublin (C.M.B.), has spent most of her life in India, her father having been the first head master of Bishop Cotton School, Simla. After her training she specialized in eye work, with a view to working in the East, and later on took a course in dispensing, and gained the Apothecaries' Hall Certificate. She did private nursing both in England and India, and for the last fifteen years has been engaged in missionary work, being for some years sister in charge of St. John's Hospital, Panch Howd, Poona City, and at present is doing district work with the Dublin University Mission in the Diocese of Chota Nagpur. She is a Founder member of the College of Nursing.

## IRISH FREE STATE

*Miss Nellie Healy*, the Irish Free State delegate, is keenly interested in Post-Graduate and Public Health work particularly, and is a very active and progressive member of the nursing profession. She took out both her general and midwifery training in Belfast Infirmary, and has also trained in specialized branches, such as children's nursing, tuberculosis, and infectious diseases. She also has the Health Visitor's Diploma in Dublin.

She is at present working as assistant superintendent of Child Welfare in Dublin, where a fine centre has recently been provided through the generosity of the Carnegie Trust.

*Miss Healy* is a member of the Executive Committee of the Irish Nurses Union, and was largely responsible for a most successful post-graduate week for midwives, arranged by the Nurses Union at the Rotunda Hospital, Dublin.

She has contributed many interesting articles to Irish nursing papers, and has also published several booklets on Child Welfare and kindred subjects. She has recently been elected to represent nurses engaged in Public Health work on the General Nursing Council for the Irish Free State, which is the official body controlling the profession there.

*Miss Healy* has done district nursing in the west of Ireland under the Jubilee Institute.

## NEW ZEALAND

*Miss Cecilia McKenny*, after graduating from the Wellington Hospital of Nursing, New Zealand, served on the staff of the Hospital as staff nurse, operating theatre sister, ward sister, home sister and matron's assistant, and was later appointed matron of Wanganui Hospital.

During the latter part of the war, until 1919, she joined the Hospital Ship Maheno, serving on her for a year, and then on the Reserve. She is now continuing as matron of the Wanganui Hospital.

She has taken an active part in progressive measures for Nursing Education. Offices held are: Matron, Public Hospital, Wanganui; Delegate to Central Council, New Zealand Trained Nurses Association; President, Wanganui Branch, N.Z. T.N.A.; Vice-President and Acting President of the New Zealand Hospital Matrons' Council.

## POLAND

*Miss J. Romanowska*, president of the Nurses Association of Poland, who during the war, became a voluntary worker in different social institutions, later enrolled in the Red Cross and joined a military train for injured and sick soldiers. Then she entered the Warsaw School of Nursing. After graduation she undertook to organize the first rural centre for mothers and children. As this was soon running smoothly, she took the position of Instructor of Public Health Nurses in Lwow. In 1926, she travelled on a scholarship from the Rockefeller Foundation through Belgium, France and England, studying Public Health Work and Maternity cases. Returning to Poland, she was appointed as Instructor of Public Health Nurses in one centre in Skierniewice, and of four rural centres in the same district.

*Miss Suffczynska*, secretary of the Nurses Association of Poland, studied for two years in the humanistic department of a private university in Warsaw. The war interrupted further study, and she became a teacher in a private family. After the war, the Red Cross sought volunteers to care for the sick and injured. *Miss Suffczynska* took a short nursing course and then enrolled and served

until 1921 in Upper Silesia, and with various Red Cross hospitals. She was also appointed head nurse for a centre for refugees near the Bolshevik frontier. In 1923, she returned to Warsaw and entered the school of nursing. After her graduation, she became theatre-room sister and matron in the Red Cross Hospital. In 1927, she took a post-graduate course in London. She has now been appointed superintendent of Red Cross nurses.

#### SOUTH AFRICA

*Mrs. W. G. Bennie*, president of the South African Trained Nurses Association, received her training in the New Somerset Hospital, Cape Town, under Miss J. C. Child, to whom Mrs. Bennie considers she owes her wide knowledge of the nursing profession. After training, she was appointed sister at Albany Hospital, Grahamstown, acting as matron for six months during the matron's absence.

The South African Trained Nurses Association is particularly fortunate in having a president, South African by birth and training, whose high ideals and grasp of professional matters have caused her to take a great interest in its members. She has given unsparingly of her time and energy, travelling all over the country, establishing personal contacts and spreading propaganda for the Association. As a result, better conditions are prevalent for nurses; such as, increased salaries, higher training facilities, etc.

She is a member of the executive of the National Council of Child Welfare, a past vice-president of the National Council of Women (Cape Town Branch); vice-president of the Women's Municipal Association, Cape Town, a member of the St. John's Ambulance Association, a member of the Nurses War Memorial Committee, of the Peninsula Maternity Committee, of the Mothercraft Training Centre and of the Native Welfare Society. In spite of her variety of interests, the South Africa Trained Nurses Association has first place in her affections and efforts.

*Miss Alexandra McDonald Mitchell*, who is a New Zealander by birth, is a graduate of Christchurch General Hospital, following which she was appointed acting sister. Later, Miss Mitchell attended the government Midwifery Training School at Auckland, and then accepted an appointment in the Whangari Hospital. Next she became sister of the Midwifery Training School, and eventually assistant matron of the General Hospital.

Plunket nursing attracting her attention, she took a post-graduate course at the Karitane Hospital, Dunedin, where she held relieving post as sister of that hospital, and then as a Plunket Nurse. Later she became sister on the staff of the Karitane Infant Hospital, Christchurch, New Zealand.

While on leave in England, Miss Mitchell was asked to organize a Plunket Centre in South Africa. Consequently in June, 1925,

the Capetown Mothercraft Training Centre was opened. Now Miss Mitchell retains her post as matron of that Centre.

*Miss Ann S. Gordon*, born and educated in Scotland, trained for three years at Kings' College Hospital, London, from 1895 to 1898.

After a short period of private nursing, she accepted the post of sister at the Albany General Hospital, Grahamstown, South Africa, where she remained as matron for over twenty years. During this period, she took a course in Midwifery at the Bristol General Hospital, Bristol, England.

Miss Gordon was appointed matron of the Victoria Nurses Institute, Cape Town, in 1924.

*Miss E. Frances Horn*, is a graduate of the Central London Infirmary, London, England, where she later held the post of home and theatre sister for one year. In 1914, she joined the private nursing staff of the Victoria Nurses Institute in South Africa. Positions held since then are: matron of the American Native Hospital, Durban, member of the South African Military Nursing Service, ward and theatre sister, then assistant matron at the General Hospital, Kimberley.

In 1921, she was appointed health visitor for Kimberley, and passed the Sanitary Inspector's Examination. Miss Horn is a founder member of the College of Nursing, London; and president of the Kimberley and District Branch of the South African Trained Nurses Association for the past two years.

#### UNITED STATES

*Miss S. Lillian Clayton*, president of the American Nurses Association, after graduating from the Philadelphia General Hospital, became a member of the staff. After several years of private duty nursing, she became assistant superintendent of the hospital at Miami Valley, Dayton, Ohio. This was followed by the position of superintendent of nurses at the Minneapolis City Hospital, while taking up a refresher course at the university. After one year as educational director at the Illinois Training School, she was appointed to the superintendency of nurses at her own school, which appointment was further enlarged to include that of nursing director of all the hospitals under the Philadelphia Department of Public Health. During the three war years, Miss Clayton served as president of the National League of Nursing Education.

Her great contribution to nursing education, that of personal example in nursing ethics, obtained recognition in the erection of a bronze tablet, unique in the annals of nursing, and presented to her by the graduate nurses of the hospital in 1929. Her great devotion to duty and the honour in which she is held is expressed in gracious language on the bronze.

*Mrs. A. L. Hansen*, born in Leeds, England, received her preliminary education at private schools. She graduated in nursing

from Buffalo Children's Hospital Training School. After spending some months in post-graduate work there, she held the position of staff nurse, and finally charge nurse of the North American Civic League for Immigrants. She was also superintendent of the District Nursing Association of Buffalo for nine years. She has held many presidencies: of the New York State Organization Public Health Nursing, of the Alumnae Association, and of the New York State Nurses Association. Now, in addition to being president, National Organization for Public Health Nursing, she is the Director of the Visiting Nurse Association in Buffalo, New York.

*Miss Burgess* is a native of New England and possesses to a marked degree the durable qualities of character said to be characteristic of that section of the country.

Upon graduation from the Roosevelt Hospital School of Nursing, in New York City, she immediately began her life work in nursing education. She taught successively at Bellevue and St. Luke's in New York, at Michael Reese Hospital in Chicago; returned as State Inspector of Nurse Training Schools. During the war she became Assistant Inspector of Nursing Service. After the war, she became Secretary to the Board of Nurse Examiners and lecturer at Teachers College, Columbia University. Now she holds the position of Associate Professor of Nursing Education. She has served on many important committees in Private Duty and Nursing Education, and has been elected president of the National League of Nursing Education.

*Miss Adda Eldredge*, a past president of the American Nurses Association, and a member of the Board of Directors, obtained her professional education at St. Luke's Hospital, School of Nursing, Chicago, Illinois, and Teachers' College, Columbia University, New York.

Many types of nursing have come within the scope of Miss Eldredge's professional activities, private duty, teaching, and public health nursing all being included in the range of her interests. She was instrumental in securing state registration in Illinois. As Inter-state Secretary of the American Nurses Association, she contributed much to the state and local organizations and helped to stimulate the association to become the official instrument it now is, for the advancement of nursing and of nursing service in this country.

She assisted with the student nurse reserve of the Council of National Defence

during the war, and worked with the New York State Board of Nurse Examiners. She assisted also with the study of nursing made in 1921 under the auspices of the Rockefeller Foundation.

Miss Eldredge has served in many capacities in her organization and from 1924-1928 was president of the American Nurses Association. She now is a member of the Board, and an active participant in committee work. She is the Director of Nursing Education of the Bureau of Nursing Education of the Wisconsin State Board of Health.

In addition to her membership in the three national nursing organizations, Miss Eldredge is a member of the National Association of Administrative Women in Education, of the Business and Professional Women's Club, of Madison, Wisconsin, and an associate member of the College Club.

*Miss Susan C. Francis* was born in Pennsylvania, and received her preliminary education in grade schools and in high school. She took her nurse's training at Reading Hospital, Reading, Pennsylvania, and during the past 20 years has held positions as Superintendent of Nurses, Jewish Hospital, Philadelphia, Pennsylvania; Director of Nursing, Pennsylvania-Delaware Division, American Red Cross; Superintendent of Children's Hospital, Philadelphia, the position she now holds. Miss Francis was elected secretary of the American Nurses Association in 1926, and was re-elected to that office at the biennial convention in 1928.

#### CANADA

*Miss Mabel F. Hersey*, president of the Canadian Nurses Association and superintendent of nurses, Royal Victoria Hospital, Montreal.

*Miss Jean E. Browne*, Toronto, director of Junior Red Cross, Canadian Red Cross Society, and president of the Canadian Nurses Association, 1922-1926.

*Miss Mabel F. Gray*, assistant professor of nursing, University of British Columbia; honorary secretary, Canadian Nurses Association, 1922-26, and acting president, 1927-1928.

*Miss Ruby M. Simpson*, honorary treasurer, Canadian Nurses Association, 1923, and assistant director, Division of Public Health, Nursing, Department of Public Health Province of Saskatchewan.

*Miss Margaret Murdoch*, member of the Executive Council, Canadian Nurses Association, and superintendent of nurses, General Public Hospital, St. John, N.B.





## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

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### Staff Education

*Providing for the Development and Growth of Staff and the Improvement of Instruction Through In-Service Education*

By EILEEN C. FLANAGAN and KATHLEEN B. HILL, Royal Victoria Hospital, Montreal.

It is a striking fact that in nursing literature, references to "in-service education," as a definite policy, affecting the graduate staff, are almost lacking.

The first and almost only recognized efforts made have been by the Alumnae Associations and the nursing journals.

There is a great deal of criticism levelled at the head nurse today. "She is too narrow." "She does not stay long enough in one position." "Teaching on the wards has deteriorated." "Head nurses have not the proper point of view regarding the students' needs, and they lack an objective, which detracts from concentration on the teaching of nurses." Are these criticisms justified? We think that, to a certain extent, they are. But are the head nurses being given any encouragement in adapting themselves to the changed needs of nursing education, or being given any opportunity for self-development?

The fundamental processes necessary in developing an institutional nurse are:

1. Those preceding the special training of a nurse—heredity and education.

2. Preparation in the training-school, which includes a high ethical sense, training in the social graces, proficiency in technique, natural ability and development through large responsibility.

3. Post-graduate work in its broadest sense.

This third phase, the post-graduate, is the subject we are considering.

A committee of the Rockefeller Foundation states that: "the chief function of a hospital executive is to create an environment conducive to the spontaneous creative expression of the group working within the organization." Therefore while it is the duty of those in charge to direct and help the staff in its work, it is also their duty to engender an interest and enthusiasm by giving each member of the staff the chance of expressing any original ideas, and of carrying these out to any extent feasible. This is what keeps interest and enthusiasm alive in a round of routine duties.

In the nursing service, these results should be brought about through the media of the superintendent of nurses and the head of the teaching department. The psychologists tell us that appreciation is taught mainly by exposing people to those who like the things we wish the people to like, and by attaching satisfaction to the experiences connected with appreciating. In applying this principle to our needs, we desire to find reflected in the members of the staff the qualities which should epitomize the leaders. Words of appreciation, sufficient help to make possible satisfactory work, honour where honour is due, and promotion as deserved, all contribute to the end result.

These, then, are some of the ways by which the right attitudes may be

built up, and we would suggest several methods of sustaining them.

In the first place, it is necessary to take account of the extent to which residence in the institution restricts the personal life of the staff. Their general outlook would tend to broaden, if where practicable, salaries and hours of duties were arranged, so that they might live outside.

While we all acknowledge the value of wide reading, we also have to acknowledge that, in this respect, nurses do not and cannot live up to their ideal. The nursing and medical journals and the newest nursing books should be available, but also a book club among the staff would be a great asset. If at the beginning of each year, the members discussed the reviews of the new books and bought a number of representative ones, these could be used by each in turn and finally given to the general library.

Extra-vocational activities are being more and more stressed for the student nurse, and should not cease when she belongs to the graduate staff.

These interests would be an important factor in making the institutional life more attractive. To enumerate a few: badminton, tennis, swimming, a bridge club, visits to places of interest in the community, membership in the art gallery, in the Women's Canadian Club, the Daughters of the Empire, or the Dickens Fellowship. One of the most attractive ideas is that of a summer camp within reasonable distance.

In addition to church interests, the graduates could participate in the Student's Christian Movement, branches of which are found in several schools of nursing.

Secondly, in enlarging the professional outlook, we would suggest a system of "rotating service," between the head nurses of at least the general medical and surgical services, the public and private wards, and from day to night duty. This rotation could be carried out for a period of a month, and in such a way that not more than two or three wards would be involved at one time. Where this

method would not be feasible, as in special wards and services, the object could be partly accomplished by having the head nurses occasionally visit these wards when demonstrations were being given, and for the regular staff rounds.

This would lead to larger experience in the members of the staff, and brings us to the next plan, which is rotation in a broader sense, that is, exchange of service between hospitals in the same city, or better still, in different cities. This would be particularly valuable in operating room work and other specialties. The ideal length of time for exchange would be one year, but six months has been found to be very satisfactory.

The *raison d'être* of these schemes is the dissemination of the varying and changing viewpoints, of new clinical ideas and of the latest methods both of teaching and ward management. The rotation system would be very helpful in preparing the new graduate for work afield. This interaction is a stimulant to all, at home as well as abroad, because of that side of human nature, which makes us put our best foot foremost.

The plan of having the members of the staff meet for discussion, is being carried out in many hospitals, and in a few such as Bellevue, it is becoming a well-recognized policy. Their scheme seems to embody all the necessary factors, and we shall use it here as a good working model. The supervisors and head nurses meet separately, but occasionally together.

The programmes are arranged in advance, and during the year every member of the staff is given an opportunity to contribute. The classes begin with a discussion of principles of teaching, and these are applied to concrete situations on a ward, such as the morning and evening reports, introduction of new student-nurses, and the holding of clinics. These situations are then demonstrated by the head nurses themselves. Criticism and discussion follow. Besides these subjects, a series of talks is given on housekeeping problems and ward

management. These meetings have been found to increase interest and efficiency, to better organise ward teaching, to clear up misunderstandings, and apparently to reduce the number of resignations.

We also think that every member of the staff should have an interview periodically with her superintendent, for in private talks any personal matter may be discussed, and the setting aside of a definite time proves a time-saver in the long run.

Another factor available for in-service education is the use of extension courses, now given so freely by the Canadian universities. Where this is impossible lectures may be arranged within the hospital, and summer courses can also be followed.

The "rating" system which is used and advocated in general educational schools by which teachers may check themselves and be checked by others, might be helpful to a certain degree, but at present would cause greater difficulties.

In our discussion so far, we have outlined some ways which might help to reduce the too frequent turnover attributed to the graduate staff; suggested ways of giving them the objective, the lack of which is deplored, so that they may be better teachers.

The instructors must work very intimately with the head nurses, if the best results are to be obtained. The criticism of the deterioration of the teaching on the wards will be

unnecessary when, theory being the complement of practice, and practice the complement of theory, the term "head nurse" and "teacher" is synonymous.

The methods we have outlined apply to hospitals having a large staff, with varying interests and plenty of material, for instance, teaching hospitals. However, there are many smaller institutions, where these methods would have to be modified to meet the existing situation. The material, though limited, is readily accessible; the interests, of necessity, are narrow; the opportunities for social contacts, few; and, here, more than anywhere, the personal equation is a deterrent factor, unless the staff is able to adapt itself to the conditions of the community.

The burden, therefore, of in-service education in any institution falls primarily on the shoulders of the superintendent of nurses, who must first exercise a good deal of discrimination in the choice of her staff, and then imbue them with her own enthusiasm and ideals; secondly, on the director of the teaching department, who should have an interested and sympathetic attitude towards the ward problems, and lastly, on the graduate herself, who must be open-minded on this subject, and loyally appreciative of the efforts made on her behalf.

"Adult life will eventually come to be regarded, not simply as a putting into practice of education already received but as a process of continuing education with living."

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## *Mental Hygiene and Nursing*

GEO. A. DAVIDSON, M.D., Senior Assistant Physician, in Charge of Reception Services, Hospital for Mental Diseases, Brandon, Manitoba.

For some years now medicine has concentrated on prevention of disease more than cure. Although mental medicine has been described as the Cinderella among the other branches of the profession, it has been taking its place in a humble manner during

the last few years. If prevention is to be aimed at in medicine generally then it must be aimed at particularly in mental medicine. After all, most of our mental disorders are due to bad mental habits, and if these bad habits are left uncorrected then one

sees difficulties setting in during later life. Most of these bad habits of thought are formed in the home. This article will be confined to mental nursing outside of mental hospitals with a view to pointing out a few features which are characteristic of mental disorder. Due to the very limited space only a brief account will be given.

Habits are largely formed in childhood, and it is at this period that faulty habits of thought may be easily corrected. Wm. A. White says that "the mind is wax to receive but marble to retain" during childhood. Timidity, shyness, sensitiveness, undue suspiciousness, obstinacy and temper tantrums are all things which cry out a warning that they might at a later period cause serious mental trouble. The people who are constantly in contact with children should be trained to recognize these things which later develop into serious disorders. The opportunity for school and public health nurses is great. They owe it to the public generally to receive training to recognize abnormal types. One may be almost certain that the shy, sensitive and timid child, who would rather sit by himself in a "dreamy" manner than to get out and enter into the sports and games of the other children, is an unhappy child who has probably a number of emotional conflicts even at such an early age. Again the child who cannot play with the others without quarreling, demanding his own way in everything, going into temper tantrums if this is not given to him and being generally disagreeable and disliked by the other children, has without doubt had an unfortunate bringing up which will handicap him in the battle of life in later years.

The child with few interests must be given interests. His teacher and others who handle him must gain his confidence and find out what is back of his reserve. She must see that he is learning to "give and take" with other children. Progress may be quite slow, particularly if there are conflicts in the home which tend to

suppress and intimidate the child. It is just as important that the self-willed child be taught that he must respect the rights of others if he wishes to get on in society. These are things which are corrected fairly easily in childhood, but become more and more fixed as the years go on.

Some of the mental hospitals in Canada are equipped with training schools for nurses. In Manitoba the mental hospital has offered a two-year course in mental nursing. At the end of this time, if proving satisfactory as nurses, and passing the required examinations, they are granted a diploma in mental nursing. This year the course was lengthened to three years. It is felt that nurses who have completed this course should be given some recognition by the nursing profession as a whole, and that some affiliation should be granted so that if they so desire they can go on and receive their general hospital training by taking an additional two years (or whatever period may be set). That is, the work which they have taken in mental hospitals should be given some recognition. We feel that the nurse who has training in both general and mental hospital nursing is going to be a great asset to her profession. She will be much more completely fitted to deal with **all** types of patients and equally important, she will lose that unreasonable and prejudiced fear that the public and the profession have for people with mental disorders.

### Summary

In summing up, then, may we point out the need of:

1. Recognizing mental abnormalities, particularly in children;
2. Preventing the development of these abnormalities and correcting them when found;
3. Proper handling of children who already show suspicious characteristics;
4. The recognition of the work being done in the training of nurses in mental hospital work.



## Summer Relief Nurses

By PEARL L. MORRISON, F.B.C.N., Superintendent, McKellar General Hospital, Fort William.

There is a problem to be met in many hospitals at the present time due to crowded space in the nurses' residences, which may be solved in a new way which from my own experience of one year has been a comfort. This method I discovered in England during my investigation there last year, which there, had been very successful.

Many of our hospitals in Canada have not enough nurses for their needs, due to not enough room in the nurses' residences. As hospitals have grown so quickly, nurses' residences have not kept pace with them\*. This means difficulty in admitting pupils in desired classes, as there are always members of last year's class left to put in time lost through illness, which hinders their place being filled by new probationers at the right time. It is impossible to admit probationers after April 1st at latest, as classroom instruction must cease during vacation months. If then, several of the graduating class which are due to leave in March have long sick time to make up, it means a depleted staff during the vacation period when nurses are needed worse than ever. It was the overcoming of this difficulty that seemed to me a great discovery, or rather I benefitted by someone else having discovered it, in England. I had not heard of its use in Canada or the United States.

This may be done by circularizing the high schools for graduating pupils who wish to grasp an opportunity to find out if they might be adaptable to nursing, and have not so far decided. There are many girls who "wonder," but do not get to the stage where they are certain enough to announce to their friends that they intend to follow nursing, wait months for admission, go to the expense of

equipment, etc. These girls are asked if they would like to enter as summer relief nurses, that is for July and August following close of school, with uniforms provided, and allowance and privileges of first year pupils following probation. This compensates for lack of classroom teaching and they are given a little, such as bed making, etc., on the wards. They help the nurses in so many ways, and relieve the vacation shortage, occupying the beds released by those on delayed time, or vacation. In return they are getting valuable experience for themselves and deciding whether they like the work well enough to follow it by entering as regular probationers (at no cost whatever to themselves, and in so far as maintenance is concerned as well as allowance, they are ahead). Again, they can be judged as to capabilities for nurse training, and encouraged or discouraged to continue.

Last year we tried this in our hospital and found it a decided advantage. Eight students were admitted; one proved to herself (and us) that she was quite unfitted for nursing in two days' time, yet had previously decided definitely to be a nurse, though knowing nothing about it. One was a school teacher who had long wished to train, but hesitated about giving up her school and wanted to be sure. She had already taken a school for the fall, but will enter training this fall. The third was a matriculation pupil whose parents persuaded her to add one more year schooling to get honours and enter training this year. The remainder stayed and entered for probation training in September, having decided they did not wish to leave it at all. Already we have various requests for this summer.

This seems to me a very successful result of a new idea, a benefit to high school students making a difficult decision, a chance for them to observe our life, and for us to observe them;

(\*We have 200 hospital beds and 60 pupil nurses beds, 13 of which are in the hospital due to no space in residence.)

a help to them, and a help to us. The same entrance requirements can be followed as for ordinary probationers, which saves future difficulties.

For the hospital which has a nurses residence beyond immediate needs, where classes may be admitted

at regular intervals large enough to fill near future vacancies, this plan will have no attraction or need, but for the hospital situated as we are, where no such provision can be made, I hope it may solve a problem as it has for us.

## Examinations

(An Editorial from "The Nursing Times," March, 1929)

Our younger colleagues have recently been facing the ordeal of State examinations, and we trust that the sympathy felt for them by older women has been a help and support.

So much has been heard in criticism of the examination system that it is refreshing to come across a champion who admits having burned much midnight oil in cramming. This is Miss Dorothy Horne, Lady Mayoress of Bradford, who was, we understand, a schoolmistress. Presenting prizes and certificates to the successful nurses at Bradford Royal Infirmary, Miss Horne said she was not one of those people who stood up on platforms with certificates in their hands and said, "I don't think much of examinations," or who told others that they had not succeeded in passing examinations but that it did not matter at all. There is a thrill about cramming for an examination that belongs to youth. It is associated with the silence of the examination room and the peculiar smell of the ink with which we wrote the masterpieces that were to decide our fate. Yet to cram is not the ideal way to prepare for an examination, unless our memories are of such a quality, that they can

continue to hold all we put into them. It is consoling to reflect that we are less likely to forget the things that interest us than those that are merely obligatory. If the patient is the real interest, the easiest road to success is obviously to link up the theory with the actual care of the sick—not always easy, but quite a fascinating mental exercise.

Under present conditions of dovetailing examination work with practical work in the wards, it is not likely that we shall be able to dispense with cramming. We should rejoice to hear that some of the training schools were prepared to make such educational experiment as would spare the ward sister, responsible for bedside care, the frequent and painful spectacle of such constant disappearance of her staff to attend lectures. The solution of this problem, as of most of our nursing problems, is an economic one.

Happy the nurse who is able to spend a year or more on one of the attractive university courses now arranged, for she is free then to devote herself entirely to her preparation for the examination towards which the course is directed, and there should be little actual cramming.

## *The History of Nursing Society, McGill University*

By URSULA WHITEHEAD

This society originated in February, 1928, in response to a suggestion of Dr. Maude E. Abbott of McGill University, that an effort be made to promote interest in the work carried on in the early days by our nursing predecessors.

The members at first consisted of the alumnae and students of the

School for Graduate Nurses, McGill University, with several honorary members: Dr. M. E. Abbott, Dr. Helen R. Y. Reid, Miss Adelaide Nutting, Miss Isabel Stewart, Miss M. Hersey and Mother Mailloux of the Notre Dame Hospital.

Later members from the School of Public Health Nursing, University

of Montreal, joined, and this year several of the sisters from the French hospitals attended the meetings.

The society, in spite of its short existence, has had quite an active membership, and is able to pass on to future members at least a nucleus of information on Canadian nursing history.

Meetings are held at the various hospitals in Montreal and papers are prepared and discussed by the members. So far these have been on the following subjects:

- History of the Montreal General and its Training School;
- History of the Mack Training School, St. Catharines, Ontario;
- History of the Toronto General Hospital;
- Nursing in the Toronto General Hospital;
- History of the Hôtel Dieu, Quebec;
- History of the Hôtel Dieu, Montreal;
- History of the Early Military Hospitals in French Canada.

A chart has also been prepared showing the growth of nursing in the province of Quebec from its origin to the present day.

The papers have proved very interesting and are kept in the archives of the society to help in the compiling of a History of Canadian Nursing. This is one of the primary objects of the society, and as a means of contributing funds toward research in this line we are now working on a booklet on "Pioneer Nurses in Canada," with the hope of interesting our visitors at the coming Congress.

Each group of students at the nursing departments of the two universities automatically falls heir to the carrying on of the work begun by the society; we look to them in the future for collecting material on this subject of Canadian nursing that interesting information may be made available in book form for all.

### McGILL UNIVERSITY SCHOOL FOR GRADUATE NURSES

#### New Appointment to the Teaching Staff

The School for Graduate Nurses is very happy to announce the appointment of Miss Isabel Stewart Manson, R.N., B.A., to their teaching staff. Miss Manson will have charge of the courses in Public Health Nursing. Her unusual preparation and experience in the field of public health enables us to develop and broaden the scope of the courses offered. A course in Supervision in Public Health Nursing and one in Organization and Administration of Public Health Nursing will be added to the curriculum.

Miss Manson is from Western Canada, where she received her preliminary education. Before entering the field of nursing, Miss Manson attended the Normal School at Saskatoon and taught for one year. In 1919 she entered the University of Saskatchewan, graduating in Arts in 1922. Directly following, she entered the School of Nursing at the Presbyterian Hospital, New York City, graduating in 1925. Her course in nursing included four months' experience in visiting nursing with the Henry Street Visiting Nursing Association, together with correlated lectures in Public Health Nursing at Teachers' College, Columbia University.

Miss Manson then joined the staff of the Victorian Order of Nurses in Winnipeg. While there she was granted a Victorian Order scholarship for post-graduate study in the Public Health course given by the

League of Red Cross Societies in London. This course is arranged by the League in co-operation with the College of Nursing and Bedford College for Women (University of London). Lectures were held chiefly at Bedford College. The field work included time with health centres in and out of London, a metropolitan borough health council, and visiting with health visitors and the Queen's Nurses working both in London and rural areas.

At the invitation of the League of Red Cross Societies, Miss Manson, with other international students, had the privilege of visiting Paris and other centres to study public health nursing in France. The course was extremely valuable, not only because of its content but because of the unique opportunity of intimate association and discussion of health problems with nurses representing almost every nation. On her return, Miss Manson was appointed as an assistant teacher and supervisor with the Victorian Order of Nurses in Montreal.

Miss Manson comes to us with the highest recommendations as a field worker, teacher and supervisor. Her ability, academic and professional qualifications and experience therefore insure a sound instruction and preparation of the students in public health nursing at McGill University.—Bertha Harmer, R.N., M.A., Director.

## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
Miss THERESA O'ROURKE, 733 Arlington St., Winnipeg, Man.

### *An Interesting Case of Diphtheria*

By F. S. MACPHERSON, M.D., Edmonton, Alberta

A little girl, aged 9 years, when first seen about 11 p.m. on November 21st, was much prostrated and having a hard struggle for air. The odour at a distance of ten feet from the bed was extremely offensive. Closer examination showed both sides of the nose to be filled with membrane and the usual thin watery discharge of diphtheria issuing from both nostrils. The soft palate, uvula, tonsils and base of the tongue were covered with extensive greenish colored membrane. The history was that the patient had complained of sore throat four days previous. The diagnosis of extensive advanced diphtheria was evident, and she was removed to hospital at once.

On admission her condition was T. 101.2, P. 116, R. 26. About midnight she was given 20 thousand units of antitoxin intramuscularly. In one hour she received 40 thousand intravenously. Her condition during the night was very poor. She was extremely dull mentally, pulse very rapid and intermittent as to rhythm and volume, and respirations quite irregular both as to depth and rhythm. A marked degree of cyanosis was present constantly.

At 6.30 a.m. November 22nd, the nurse became so alarmed that the attending physician was summoned hastily as well as the parents and priest, as it appeared that death was imminent. About 9 o'clock she received a further dose of 40 thousand units intravenously. The nurse's note for 12.45 noon is "colour improved, pulse fair quality." At 8 p.m. there was evidence of the membrane commencing to separate. The next day she received a further dose of 20 thousand units antitoxin intramuscularly.

The only complication of any moment was an acute nephritis. On the tenth day after admission the urine showed albumen, "heavy trace" pus and granular casts and the 24-hour excretion, ounces 13. The thirteenth day the total output was ounces 8. The condition gradually improved so that on the 16th day the total output was ounces 24, and next day ounces 34.

Having in mind that terrible ghost that haunts all severe diphtheria cases, myocardial failure, the patient was kept as quiet as possible. However this patient did develop some neuritis, and consequent paralysis, but fortunately only of the palate and ciliary muscles. The former was evident on the 29th day by nasal quality of the voice, and the latter was discovered on returning home and given the "funny papers" to look at. She could not read nor even make out the pictures. Both these instances of neuritis cleared up in about two weeks.

The patient was discharged from hospital on the 29th day after admission (or the 33rd day of disease), and removed home in the recumbent position on the promise of the parents to keep her quiet in bed for two weeks.

It seems almost unnecessary to note that this patient had not received the toxoid prophylactic injections owing to the opposition of the parents. Now, however, all of the children are to receive this treatment.

Many among the laity believe that the severe forms of paralysis following diphtheria are the direct result of antitoxin. It is, however, pretty conclusively proven that this view is incorrect, that the cause of such nerve damage is toxin as shown



by the comparatively large dosage of antitoxin and insignificant amount of paralysis shown in this case.

In summing up there are one or two points illustrated by this case that should be stressed:

1. At least one hour before administering antitoxin intravenously, a dose should be given intramuscularly to ascertain presence or absence of hypersensitivity for foreign proteins, i.e. anaphylactic shock.

2. The intravenous method of administering antitoxin, given slowly, is safe, the action more rapid and much more effective.

3. Dosage—As we cannot measure or even estimate accurately the amount of toxin the proper dose of antitoxin must always be uncertain. An initial dose under 20M. has little, if any, curative value. An average case should receive 40M. first dose, and a severe case from 80 to 100M. first dose.

#### Nursing Care

The nursing care of the above reported case is described by Miss Frances E. Welsh, superintendent of nurses, Isolation Hospital, Edmonton.

The nursing care of Dr. MacPherson's case of diphtheria might be

regarded as one of those extreme cases requiring constant and strict observation with unremitting nursing care.

The patient was kept in a recumbent position with the foot of the bed elevated for eighteen days, and was not allowed to help herself in any way either to read, amuse herself with toys or feed herself.

Steam inhalations were constant. Listerine and hydrogen peroxide sprays were used to cleanse the throat and the nose, and frequent sips of water kept the mouth moistened. The swollen glands were treated with antiphlogistin, and enemata were given in preference to laxatives during the severe stage.

As there was great difficulty in swallowing, the diet at first was restricted to light liquids, and increased as the throat improved.

When the kidney complications appeared the patient was immediately placed between blankets with a strict liquid diet, while the usual routine of urinalysis was carried out. The daily purge of magnesium sulphate was also given at this stage with a liberal supply of fluids.

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### *My Most Interesting Case*

By MAUREEN CARLEY, Victoria, B.C.

The private duty branch of nursing offers untold opportunities for coming in contact with all that is interesting in the nursing profession. It is the special duty nurse who attends the patient at the height of the illness, for as a general rule it is only when a patient is very ill that a special nurse is required; then she is there to note every symptom, and watch the development of the case for any indications of complications.

Each of fifty-four cases I have had since graduating two years ago has been of a totally different nature, so that to one new in the field they were a constant source of interest.

Of these probably the most interesting, was a case I was fortunate enough to have a little over a year ago. This patient had been in poor health for about fifteen years, was thin and unable to gain in weight, there was a chronic acne condition of a very severe form, and she was subject to severe colds. Other than this there were no definite symptoms.

She was admitted to hospital for observation and examination. After a cystoscopy it was discovered that one kidney had ceased to function, and in all probability had been in this stagnant condition for many years.

A nephrectomy was performed and one kidney removed which weighed five pounds (normal kidney weighs approximately five ounces). The interior of the kidney revealed huge cavities filled with pus and stones, some of the stones being more than an inch in diameter.

The patient, though her condition was poor at the time of the operation made a remarkably rapid recovery. Almost immediately the acne condition began to clear up, her appetite improved, and she made a gain of several pounds before she left the hospital. In the course of time it became evident that there was no longer the tendency to catch cold, and there was a general improvement in her condition, which has since proved to be lasting.

In spite of the serious nature of the case the patient was always exceptionally cheerful, and had a keen sense of humour.

A Royal Jubilee Hospital Bard was therefore inspired and wrote the following rhyme in honour of the departed kidney.

#### Ode to a Kidney

I had a little kidney,  
It had always lived with me.  
But it wasn't very useful  
As far as I could see.

So I took it to a doctor  
And he wisely shook his head  
"Say farewell to your kidney,  
I must take it out," he said.

So he seized the fated victim  
One Friday, in the morn,  
And I, unhappy mortal,  
Of my kidney I am shorn.

It was bashful and retiring,  
But now it bursts with pride,  
For it had its picture taken  
Front and back and on its side.

But that kidney was intended  
For a laurel greater still,  
For it went to famous lectures  
Where M.D.'s could gaze at will.

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## Book Review

**Materia Medica Note-Book**, by Mary Sewall, R.N., Fabiola Hospital, Oakland, California; published by J. B. Lippincott Company, London, Philadelphia, and 201 Unity Building, Montreal. Price, \$1.50.

This Note-Book for *Materia Medica* and *Therapeutics* is to be placed in a loose leaf folder and pages added between the index pages; thus it may be used as a guide for the teacher and pupil in the study of this subject.

Each index page contains a list of commonly used drugs in that group, in some cases supplemented with a few facts concerning their use. Each page is coloured to represent the principal action of the

group of drugs; orange colour denoting stimulation, blue colour denoting depression, and white colour denoting other groups, e.g., specifics, acids, alkalies, etc. These pages provide a definite division between the groups of drugs. The use of colour in connection with the classification of drugs intensifies this division. The orderliness of the note-book, with tabulations arranged in order, render it easily accessible for the purpose of study and review. Finally, when completed, it would make a very valuable and attractive note-book.

It meets a need as a guide in the field of *materia medica* and should be of inestimable value both to teacher and pupil.

—Mildred M. Reid.

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International Council of Nurses Congress, July 8 to 13, 1929,  
Montreal, P.Q.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *A System of School Medical Inspection\**

By F. S. BURKE, M.B., Director of Medical Services, Department of Public Health,  
Toronto

When your committee in charge of programme assigned me the paper "A Model System of School Medical Inspection," they select a subject that is very full of controversial possibilities, as few, if any, cities carry out school medical inspection in the same way. For that reason I approach it with a certain amount of hesitation. We do not all agree as to what municipal department should carry out school medical inspection, i.e., the Department of Health, or the Department of Education. We do not all agree whether it should be done by physicians, nurses or teachers, or a combination of the three. Our records are all dissimilar and our ideas on just how important school medical inspection is, and, if it is important, what special phase of it is the most important, do not agree.

By questioning the Fellows of the Rockefeller Foundation who come to us for certain work in public health, I am forced to the conclusion that more or less specialized work goes on in many cities. These men spend many months observing and I have endeavoured to get their views on the school work they have observed prior to coming to our department. These views vary. For example, one told me that in a certain city the emphasis was on posture, and that the authorities were directing their energy towards finding every "crooked" child as well as some who were not. In another city it seemed that perhaps an excessive amount of attention was paid to vision or to diet. I can quite understand this being true if

examinations are made by volunteer or part-time physicians. They are bound to stress unconsciously the specialties towards which they lean, and this is an age of specialists. On the other hand, full-time physicians with a good knowledge of public health, are more liable to apply school medical inspection in its broadest sense.

Many years ago Dr. Hastings decided that school medical inspection was a very important part of public health, and he formulated his plans accordingly. Eleven years ago he took over from the Board of Education the school health service, and by a judicious and far-sighted policy he has evolved the system which I propose shortly to describe.

First of all let us consider some of the fundamentals. In what department of the city's government should this work be placed? We are thoroughly convinced, seeing that the work is largely in the field of preventive medicine, that it rightly belongs to the Department of Public Health. There are some excellent arguments for this, particularly the fact that the school health work can be successfully linked up, without any overlapping, with the health department's existing prenatal, child welfare, and pre-school activities and with the control of communicable diseases. We are convinced also that the actual work itself should be carried out by full-time physicians selected by the medical officer of health and possessing, if possible, the Diploma of Public Health. It is possible to demand from full-time physicians a quality of work in keeping with its importance. We are all aware that a municipality can pass by-laws dealing out public health *en masse*; this is an impersonal thing. But it is only at the school medical

(\*Presented at the annual meeting of the American Association of School Physicians, during the meeting of the American Public Health Association, Chicago, October, 1928, and reprinted from the "Canadian Public Health Journal," January, 1929.)

inspection that we have the opportunity of meeting the unit of population. It is there that the opportunity is given us to talk quietly and privately to the child and his mother. It is at the school medical examination that we have the one opportunity of bringing the human element to bear on the budding instincts of the child and at the same time to gain the mother's confidence and respect. Furthermore, these examinations take place when the child is at an impressionable age, in the building where he goes for all his learning; the work is carried out in an atmosphere which tends to make the child understand it to be part of his general education. The physician has the opportunity of laying the foundation for future periodic health examinations and above all, through his impersonal interest in the general welfare of the school child, he is armed with a powerful weapon for the defence of orthodox medicine and he can guide the parent back to the safest path known, that of the family physician. You must agree then that this work is worthy of the highest qualifications; its effects are too far-reaching to be placed in lesser hands.

For purposes of health administration Toronto has been divided into districts. The boundaries of these districts are influenced to a certain extent by natural barriers, such as watercourses or ravines and the main lines of railways, and by the number and size of schools, as it is important that the district medical officer should be able to complete his round of school work each year. One district is much like another in that it has approximately 60,000 to 70,000 inhabitants with about 10,000 school children. A district office is maintained at a strategic position and in most districts sufficient space has been found available in police stations. These offices are in no way intended for the reception of sick or for holding clinics, but are solely for purposes of administration.

The personnel of a district office consists of the district medical officer, the district superintendent of nurses,

eight or twelve nurses, all full-time, and the representative of the social agencies, in our case the Neighbourhood Workers' Association, also full-time. Thus, we have a self-contained unit ready to deal with any routine question that may arise in that district, but, of course, referring any problems involving the policies of the Department to the Medical Officer of Health.

It is demanded of the district medical officer that he visit and work each school once a week, preferably on the same day and hour, and maintain that schedule throughout the term. We have schools in which the doctor's weekly time-table has not changed in seven or eight years. This gives the district mothers an excellent opportunity to bring their problems to the school doctor, and to discuss the welfare of their children. A district should have the equivalent of 10 schools of about 25 classrooms of 45 pupils. A district medical officer examines approximately 2,500 children per school year.

If I were asked, "What is the most important function of the school medical officer?" I should at once reply, "Health teaching;" and to accomplish that, it is necessary that the mothers be present at the routine physical examination. Last year out of 22,000 children examined, 11,000 were accompanied by a parent. We consider it rather more important that the parent should accompany the six-year-olds, and our percentage of parents rises to about 70 per cent in this group.

The examination should be made with the consent and co-operation of the parent, and we have educated the public to this point where probably less than one per cent object to any type of examination. Four or five per cent tolerate our efforts with great Christian fortitude, but the balance are with us; some may be critical, but they are not hostile. The examinations gain greatly in importance by being made in private, that is, mother and child, nurse and physician. The child should be stripped to the waist, except of course, in the case



of the older girls, and each organ commented on as the work proceeds. For instance, it means very much more to the mother to be told that the child's lungs are sound than that the child is normal. I think we should never overlook the fact that to the parent it is just as necessary to stress the negative as the positive findings. Following the examination the findings should be summarized for the mother's benefit. When a defect is found I do not think it necessary for the district medical officer to attempt to make the ultimate diagnosis there and then. I think it is sufficient for him to decide whether or not a defect exists, whether the case needs either supervision or correction by the family doctor or hospital. He should make sure that the parent understands this and should describe the effect on the child's future career if the defect be left uncorrected. He should notify the family doctor\* that the parent has been told of the existence of an apparently abnormal condition, and for the time being, that is as far as the matter should concern the district medical officer, the nurse making the next contact.

(FORM LETTER)

Date.....

Dr.....

Dear Doctor:

I am instructed by Dr. Charles J. Hastings, Medical Officer of Health, to bring to your attention a school child by the name of

.....  
 living at.....  
 and attending..... School.  
 whose parents state that you are the family physician.

Owing to the opportunity afforded us for the almost constant observation of this pupil by teacher, nurse and finally the school physician, the following apparently abnormal condition has been noted and the parents advised to consult you.

.....  
 If there is anything that the Department of Public Health can do to aid in follow-up, subsequent to your treatment, please telephone the district office.

Yours truly,

M.B.

District Medical Officer.

The time consumed by the examination of a normal child is 10 to 12 minutes, so that the physician can examine about 16 children per morning. To this must be added other miscellaneous work the nurse may present for solution. Amongst the older children whose history has been well followed throughout the school year, a better rate of approximately 20 examinations per morning can be attained.

A school medical officer should have sufficient time at his disposal to make a final examination of the pupils in the graduating class before they leave the public school system. He should check up on any abnormalities that have been recorded against a child, making a final comment on the card concerning them. But above all, he should give the child vocational guidance in case his school career should end at this time.

In the month of June, just before summer holidays, the defect files should be inspected, and each child with an abnormal condition should be seen in order to check up progress or otherwise and have recorded upon his card anything of note. The findings of this review of the defects give each school nurse sufficient home visiting to carry her through the summer. It also gives her renewed assurance in pressing for action on old cases. It gives her a fresh list of urgent cases. It renews and freshens her interest generally.

The number of examinations in public school life, or the frequency with which we should make these regular physical examinations depends on several correlated activities. It depends upon how close a contact or supervision the school nurse is able to maintain, and at what intervals the district medical officer visits the school. If, for example, the school nurse visits the school daily, and the school medical officer weekly, I believe that not more than two or three routine physical examinations are necessary in the public school life of a child. I think it is generally accepted that the majority of defects

(\*See form letter to physician.)

have already developed when a child reaches the age of 6 years. Between 6 and 12 years the new defects developing are largely those of vision and hearing and defects arising out of infectious diseases. Vision and hearing defects are usually soon detected by the teacher who has a daily opportunity of referring them to the nurse. Defects following infectious diseases are often reported when the child returns to school, following the release from isolation. If then we decide to do the minimum number of examinations with adequate follow-up, I would suggest a thorough examination of every child upon entering the junior-first class. This usually represents an average age of 6 years. At this examination will be found any abnormal condition militating against a normal school career. Past experience has shown us that 35 per cent of this age group have abnormalities. Parents as a whole are willing to co-operate in the correction of defects if one can prove that the existing defect will prevent the child from doing well in class. The next routine physical examination is carried out in the junior-fourth class. This represents an average age of 11-12 years, and amongst other things this examination should be the starting point of vocational guidance in those who have permanent abnormalities. This age group averages about 30 per cent abnormalities most of which have made their

appearance since the primary examination in the first class.

These two routine examinations in Jr. Ist and Jr. IVth are sufficient for the majority of pupils but there is another group, the dull normals, whom we are liable to overlook unless we institute an examination by age and not by academic attainment. In other words, there is a substantial group who are not in the special classes for the mentally retarded, yet never advance beyond a certain point in their studies, and who do not get to the Jr. IVth by the time they are 12 years old. It is suggested then to ask each principal annually for a list of those pupils who are 12 years old in all grades under the Jr. IVth. This plan gives these children a yearly examination and these are the ones above all others who require vocational guidance. The other groups that should receive more than average attention and not less than one routine physical examination per year are those in the sight-saving, deaf and "hard of hearing," mentally retarded and open air classrooms, also in the forest schools; in other words, all children selected for any form of auxiliary teaching should receive more than the ordinary amount of medical supervision. Pupils in classes for crippled children should be seen by a psychiatrist as well as by the school medical officer.

(Concluded in June issue).

### *Health Examination for Normal School Students*

The Manitoba Department of Education has been requiring normal school students to pass a medical health test. As a result of the test quite a number of students had to withdraw this fall from the several classes. The examination was conducted by medical men appointed by the Government of each centre where the normal schools are situated. In addition to the tests for physical

fitness, tests were also made in oral English, written English, and silent reading. Several students failed in these tests also. On the whole, the health tests revealed that a larger proportion of the normal students were of poor physique than is generally thought. The Department purposes emphasizing physical instruction in secondary schools. (The School, Toronto, Ont., December, 1928.)

## *Imperial Baby Week*

### *Challenge Shield Competition*

The National Baby Week Council, England, awards annually a handsome Silver Challenge Shield (donated by the "News of the World") for the most effective local Baby Week Campaign held throughout the Empire, including the Irish Free State, but excluding the British Isles. Conditions vary enormously throughout the Empire, and therefore each campaign is judged on its merits, particularly in relation to the way in which it is devised to meet the peculiar circumstances of the district it is to cover.

The Shield was won for 1926-27 by the Health and Baby Week Committee of Bellary Municipality, Madras Presidency, India, and for 1927-1928 by the Baby Week Committee of Benoni, Transvaal, South Africa.

The regulations of the 1929 competition are announced as follows:

1. A Baby Week Committee may be formed by any municipality or voluntary body for the purpose of organizing a Baby Week in any geographical administrative area within the British Empire, including the Irish Free State, but excluding the British Isles.

2. Any Baby Week Committee so formed is eligible to compete for the Imperial Baby Week Challenge Shield.

3. A Baby Week Campaign, which must be announced as such and which may or may not, according to the discretion of the Competing Committee, be combined with a Health Week, must be held between June the 1st, 1928, and such time as will enable the records to be transmitted to, and received by, the National Baby Week Council Office in London, on or before June the 1st, 1929.

An extension of closing date to June 14th, 1929, will be allowed in the case of entries from those places (Australia, New Zealand, etc.), in-

volving five weeks—or more—mail transmission to England.

4. Competing Committees must supply the following information:

(a) Entry Form on which is to be given certain information specified thereon. This form is attached to this sheet. Copies may be obtained direct from the National Baby Week Council, or from the Imperial Headquarters of the area concerned.

(b) A full description of the programme carried out together with an account of the special difficulties and problems presented by the local conditions as they affect the welfare of mothers and little children. Such accounts may be illustrated by photographs, and should be accompanied by copies of any leaflets, posters, and similar propaganda material used in connection with the Campaign, also by cuttings from articles in the Press which have preceded, accompanied or followed the campaign as being part of the local Baby Week activity. Special attention should be given in this account to any novel features (such as the use of special films) and of any ingenious devices to secure local interest.

N.B.—In awarding the Shield full consideration will be given to the measure of initiative and energy spent in carrying out the appropriate scheme.

NOTE.—It should be borne in mind that a local Baby Week Campaign is intended to be purely of a propaganda and educational nature, and must not in any way be made the medium for furthering the interests of any commercial undertaking.

Entry forms may be obtained from Dr. Helen MacMurchy, Chief Welfare Division, Dominion Department of Health, Ottawa, or the Chief Medical Health Officer of each Province. (Canadian Child Welfare News, Feb., 1929.)

## INTERNATIONAL COUNCIL OF NURSES—Montreal, July 8th-13th, 1929

The Committee on Arrangements for the Congress ask that:

1. All nurses who have completed their arrangements regarding rooms during the Congress, and have not sent to the secretary information regarding personnel of party and branch of nursing engaged in, please do so as soon as possible.

2. It is absolutely essential that nurses state upon what date they expect to arrive in Montreal before reservation can be made.

3. Nurses are urged to send requests for reservations to the office of the Arrangements Committee as soon as possible.

4. Nurses who have booked reservations in more than one hotel, when only one is

needed, are requested to notify the secretary as to their choice, so that fair play may be accorded to all.

5. Nurses are requested not to make application for accommodation for others than nurses, as choice accommodation is limited.

6. There are no more single rooms or rooms for two persons now available in hotels, unless parties of two will accept double beds. There is no more available accommodation at the Y.W.C.A., and rooming houses are asking that very large rooms for four persons be accepted; some of these will be equipped with double beds only. There are, of course, many single rooms, too, in rooming houses.

Miss Margaret Moag, convener, Transportation Committee, has submitted the following information for publication:

The Canadian Passenger Association has authorized reduced fares on the Identification Certificate plan for all who will attend the I.C.N. in Montreal. Upon presentation of Identification Certificates round trip tickets at fare and one-half will be issued.

Dates of sale are as follows:

	Dates of Sale	Return Limit
<b>Eastern Lines—</b>		
From east of and including Armstrong, Fort William, Sault Ste. Marie, Ont., and the St. Clair and Detroit Rivers .....	July 4-10	July 20
<b>Western Lines—</b>		
From west of Armstrong and Fort William, and including points in Saskatchewan, Manitoba and Ontario .....	July 4-10	July 20
Points in British Columbia .....	July 2-8	July 28
Points in Alberta .....	July 3-9	July 21

and in addition round trip tickets at fare and three-fifths, with thirty-day limit, will also be issued.

For western sections the usual summer rates may be less expensive and nurses are advised to consult local ticket agents for comparative rates and date of sale.

All tickets must be validated at Montreal before return journey is commenced. Under the Identification Certificate plan, validation simply means stamping of the ticket by the ticket agent.)

Identification Certificates may be obtained from the following provincial representatives:

Miss L. F. Fraser, R.N.,  
Room 10, Eastern Trust Co., Bldg.,  
Halifax, N.S.

Miss A. J. McMaster, R.N.,  
Moncton Hospital,  
Moncton, N.B.

Miss Anna Mair, R.N.,  
Royal Edward Hospital,  
Charlottetown, P.E.I.

Miss Matilda E. Fitzgerald, R.N.,  
279 Willard Ave.,  
Toronto 9, Ontario.

Miss E. Carruthers, R.N.,  
753 Wolseley Ave., Winnipeg, Man.

Miss E. E. Graham, R.N.,  
Regina College, Regina, Sask.

Miss Helen Randal, R.N.,  
125 Vancouver Block, Vancouver, B.C.

Miss D. Mott, R.N.,  
110 18th Ave. West, Calgary, Alta.

Miss E. Armour, R.N.,  
Jeffrey Hale Hospital, Quebec, P.Q.

All nurses should reach Montreal by the morning of Monday, July 8th, as the first meeting will be at 2 p.m.

Post-Convention tours in Canada and U.S.A. are being arranged by Thos. Cook & Son, who will shortly issue an attractive folder. Canadian nurses may obtain these folders from the same provincial representatives who will issue the certificates.



## *Annual Reports, Provincial Meetings*

### I.

#### THE GRADUATE NURSES ASSOCIATION OF BRITISH COLUMBIA

The annual meeting of the Graduate Nurses Association of British Columbia was held on April 1st and 2nd in the Vancouver General Hospital, with the president, Miss K. W. Ellis, in the chair. Between fifty and sixty nurses were present.

At the meeting of the Public Health Nursing Committee, with Mrs. John Gibb in the chair, a most interesting address by Dr. E. Johnston Curtis on "Some Aspects of Pediatric Nursing" was given; also Dr. M. D. Meekison gave an inspiring talk on "Visiting Nurses and Orthopedics."

In the Education Committee meeting, Miss Mabel Gray was in the chair. The minutes were read and reports of all special meetings were given. Then there was a visit to the Maternity Department and the Infectious Diseases Department of the Vancouver General Hospital. Tea was served by the Vancouver General Hospital Alumnae Association and the Vancouver General Hospital, after which there was a meeting of the council.

At the evening meeting at 8 p.m. the invocation was made by the Rev. C. A. Williams, and there was a most inspiring address given on "The Need for Leadership" by Dr. George M. Weir, which was greatly enjoyed by all present. The president then read her address, and the minutes of the last general meeting were read by the secretary. The registrar's report and the report of the Inspector of Training Schools were given by Miss Helen Randal; after which the ballot box for the election of officers was closed and the nurses were invited to have refreshments, which were served by the Vancouver Graduate Nurses Association and St. Paul's Hospital Alumnae Association.

On Tuesday, April 2nd, the speaker in the morning was Dr. Howard Spohn on "The Training of Pediatric Nurses," and a visit was paid by the attending delegates to the Private Pavilion of the Vancouver General Hospital and a demonstration of central dietary service was shown. Then an address by Dr. Edith Bryan, of Berkeley University, California, on "Public Health Nursing" was given.

At the afternoon session the speaker was Dr. T. H. Lennie on "The Modern Aspect of Goitre," which was most interesting. After the lectures a general discussion took place, and it was decided by the floor to send two delegates to the International Congress in Montreal and partially meet their expenses. All the reports of the standing committees were sub-

mitted to the floor and any unfinished business was dealt with before the election of officers and councillors for the coming year was placed on the board.

In the evening a banquet was held in the Hotel Georgia and Dr. Edith Bryan, of Berkeley University, California, again honored the meeting by speaking on "Mental Adjustment in Every-day Life." Dr. Bryan spoke on the necessity of individual stock-taking and the conquering of self-consciousness in public and showed how this could be accomplished by self-forgetfulness and concentration on the subject. The meeting was adjourned after a most successful session.

Officers and councillors elected: President, Miss K. W. Ellis—by acclamation; 1st vice-president, Miss M. Campbell; 2nd vice-president, Miss M. Mirfield; registrar, Miss H. Randal—by acclamation; secretary, Miss M. Dutton; convener, Nursing Education, Miss M. F. Gray—by acclamation; convener, Public Health, Miss E. Breeze; convener, Private Duty, Miss P. Cotsworth; councillors, Misses M. Ewart, Boggs, E. Franks, M. Stuart.

### II.

#### THE REGISTERED NURSES ASSOCIATION OF ONTARIO

The fourth annual meeting of the Registered Nurses Association of Ontario was held in Kingston, April 4, 5, and 6, 192 members being registered. Too much cannot be said for the arrangements made by the Kingston nurses. The spacious city buildings provided most satisfactory accommodation for meetings and exhibits. The banquet on Friday evening was held at the La Salle Hotel. Sisters and nurses of the Hôtel Dieu and the General Hospitals were hostesses at the Thursday and Friday. The Kiwanians arranged a very interesting motor drive on Thursday afternoon.

The general business meetings held Thursday morning and afternoon and Saturday morning were presided over by Miss Florence Emory, president. At the opening session, Miss Emory gave a most inspiring address, "The Challenge of the Future." The reports of committees, sections and districts showed a very gratifying progress, but also the need of much further development. The membership has increased to 1,629—an objective of 1,830 has been set for the coming year.

The officers elected for the coming year are: President, Miss E. Muriel McKee. Brantford; 1st vice-president, Mary Millman, Toronto; 2nd vice-president, Miss

Marion May, Ottawa; secretary-treasurer, Miss Matilda Fitzgerald, Toronto.

The place of the 1930 meeting is to be Toronto.

The evening open session was presided over by Miss Anne Baillie, superintendent of nurses, Kingston General Hospital. Addresses of welcome were given by the mayor and representatives of the two hospitals. Dr. F. N. Biggar, National Commissioner, Canadian Red Cross Society, spoke on the "High Cost of Sickness."

At the separate section meetings on Friday morning there were excellent papers and discussion. In the Nursing Education Section the discussion in response to a "Question Box" centred chiefly about nurses' residences, supervision of the same, and nurse instructors. In the Private Duty Section, Dr. A. E. McGhie, Hamilton, read a paper on "The Interpretation of Some of the Newer Clinical Laboratory Studies," and Dr. L. F. Austin, Queen's University, spoke on "The Evolution of Nursing." The Public Health Section was devoted to a symposium on County Health Units.

The joint round table held in the afternoon had as its topic "Mental Health." This subject was approached from the viewpoint of the home, nursing school, school, industry, and the hospital. Dr. Archibald McCousland, Kingston, directed the discussion.

At the banquet Miss Hersev, president of the Canadian Nurses Association, spoke on plans for the International Council of Nurses Congress in Montreal, following which Principal Bruce Taylor, Queen's University, gave a most witty address.

### III.

#### REGISTERED NURSES' ASSOCIATION, SASKATCHEWAN.

The twelfth annual convention and fifth annual institute of the Saskatchewan Registered Nurses Association was held in Saskatoon Public Library, Saskatoon, on April 3rd, 4th and 5th, 1929. Ninety-five nurses registered from eighteen different parts of the province.

The general meetings were well attended and a keen interest was shown by all present.

The question of scholarships was thoroughly discussed by the delegates in attendance, and as a result it was decided that a scholarship of five hundred dollars for University Post-Graduate study be given this year, open to any nurse registered and in good standing in Saskatchewan, the course to be for teaching and administration in schools of nursing.

The organization of a Nursing Education Section of the Association was decided upon. This Section will consist of all superintendents of nurses and all instructors of nurses in the province with an executive committee of five members. Meetings will be held an-

nually, at the time of the annual meeting of the S.R.N.A. The supervision of the curriculum for nurse training schools is to be one of the duties of this committee.

Three delegates to the International Congress of Nurses were appointed:

Miss R. M. Simpson, to represent the Public Health Section; Miss S. A. Campbell, to represent the Nursing Education Section, and Miss C. M. Munro, to represent the Private Duty Section.

The officers elected for the coming year are: President, Miss R. M. Simpson, Regina; First Vice-President, Miss Jean MacKenzie, Regina; Second Vice-President, Miss M. H. McGill, Saskatoon; Councillors, Miss Montgomery, Fort San; Sister O'Grady, Regina; Conveners of Standing Committees: Nurse Education, Sister Mary Raphael, Moose Jaw; Public Health, Miss Elizabeth Smith, Moose Jaw; Private Duty, Miss M. C. Munro, Saskatoon.

The programme of the Institute which followed the business meeting, included three lectures on "Physio-therapy," by Dr. E. E. Shepley, two on "Mental Hygiene, and Public Health," by Dr. S. R. Laycock, and one by Dr. Munro, "The Relation of the Medical and Nursing Profession from the Standpoint of Nurse Education."

Dr. Shepley's lectures followed a definite course in physio-therapy, beginning with the nature of physio-therapy, leading to the conditions in which physio-therapy is indicated, and concluding with practical points in its application.

Dr. Laycock's lectures dealt with mental hygiene as of particular interest to nurses. In the second lecture the mild mental mal-adjustments of the average patient were discussed.

Dr. Munro in speaking of the relation of the medical and nursing profession from the standpoint of nurse education stressed the facts that nurses in training need kindly discipline, good instruction, an understanding of the treatment they are giving, why it is given and what effect such treatment will have on the patient and the disease.

Miss S. A. Campbell spoke on "The Case Record System in the Education of the Nurse," demonstrating her points with some examples of case records which had been made by pupil nurses.

Miss Nan McMann, Western Supervisor of the Victorian Order of Nurses, addressed the meeting on Thursday, her topic being "The Nurse in the Home," and by way of illustration the V.O.N. play was given.

The visitors were entertained at tea on Wednesday, and at a banquet on Thursday evening by the Saskatoon Graduate Nurses Association. The dinner speaker, Dr. Margaret Cameron, of the University of Saskatchewan, gave an interesting address on the subject, "A Would-be Explorer of the Great West."

The convention and institute closed on Friday afternoon, the next annual meeting to be held immediately preceding the biennial meeting of the Canadian Nurses Association in Regina, in 1930.

## News Notes

### ALBERTA

**EDMONTON ASSOCIATION OF GRADUATE NURSES:** Nurses planning to attend the International Congress include: Mrs. Manson, Misses F. Munroe, B. Emerson, Welsh, Lavell, A. Conroy, M. Gould, E. M. Davidson.

Miss Ida Johnston, of the Royal Alexandra Hospital operating room staff, is taking a post-graduate course in the Woman's Hospital, New York.

Miss Gertrude Allyn (Royal Alexandra Hospital, 1927), is taking a post-graduate course in obstetrics in Montreal, and Miss English (1927), is taking a post-graduate course in pediatrics in Toronto.

**MEDICINE HAT GRADUATE NURSES ASSOCIATION:** The following are planning to attend the International Congress of Nurses in July: Misses Auger, Dixon, F. Smith, Bassett, Sodero, Ethel Murray and Mrs. W. Devlin.

Miss Jardine has accepted a position at the Central Alberta Sanatorium.

### BRITISH COLUMBIA

**VANCOUVER GRADUATE NURSES ASSOCIATION:** This Association held their regular monthly meeting on March 1st, at the Vancouver General Hospital, Miss M. Campbell in the chair.

At the end of the usual business meeting, Dr. C. W. Proud, of St. Paul's Hospital, Vancouver, gave a most interesting lecture on, "Radium, and its Therapeutic Uses." After a hearty vote of thanks, the meeting adjourned and refreshments were served.

### MANITOBA

**BRANDON:** The March meeting of the Brandon Graduate Nurses Association was held at the home of Miss Margaret Gemmill. Dr. Peters gave an excellent paper on "Obstetrics," and Miss Christine Macleod, one on, "The Tannic Acid Treatment of Burns." Miss Eva McNally, assistant superintendent of nurses, Brandon General Hospital, is slowly recovering from an operation.

Mrs. R. Darrach (Persis Johnson), who has been quite ill for some time is better.

The Brandon Graduate Nurses Association held a baking contest, sale of home cooking and tea, on March 22nd, and realized the sum of \$105.54.

**ST. BONIFACE NURSES ALUMNAE ASSOCIATION:** The members of the Alumnae enjoyed a pleasant evening in March, when Mrs. Menzies, president of the Local Council of Women, gave a very interesting address on the National Council of Women.

Miss Margaret Meehan, who has been at Alhambra, Cal., for the past year is back in Winnipeg with the Provincial Board of Health.

Misses Ethel Graham and Laura Alt, left the General Hospital, Wyandotte, Mich. recently for Clearwater, Fla.

Miss Mary Dillon returned from Rochester, Minn., where she has spent the past year.

Miss E. Payne, staff nurse at the Misericordia Hospital, is enjoying her holidays at Dauphin, Man.

Miss Irene McQuire has accepted a position on the staff of special nursing at Mayo's Hospital, Rochester, Minn.

Miss Ann Platford left last week for Allahabad, India, where she is to marry Mr. W. J. Hansen, formerly of Winnipeg, and now an Agricultural Missionary in India.

Miss Gladys Huggins left for Detroit, Mich., March 29th.

Miss Eunice Eberta has accepted a staff position in a hospital at Dauphin, Man., and Miss Alice Killen one at Ninette Sanatorium.

### NEW BRUNSWICK

**CHIPMAN MEMORIAL HOSPITAL, ST. STEPHENS, N.B.:** Miss Whyte, dietitian, has gone to St. Agathe, P.Q., for her vacation.

Miss Grace Mowatt has so far recovered from her illness, as to be able to return to her home.

Miss Loie Mersereau has accepted the position of assistant superintendent temporarily at the hospital.

### NOVA SCOTIA

**HALIFAX:** The many friends of Miss Mary Hayden, R.N., will be pleased to know that she has accepted a position on the public health nursing staff in the State of Maine. For several years she occupied a similar position with outstanding ability with the Massachusetts-Halifax Health Commission, having been one of the first nurses to take the public health nursing course at Dalhousie University.

The members of the Registered Nurses Association of Nova Scotia of which she was an active and zealous member, regret exceedingly her departure from Halifax, the city of her birth. A graduate of Mount Saint Vincent Academy, Miss Hayden later took her nursing course in the United States and is exceptionally well equipped for the position she now holds.

Previous to her departure, Miss Hayden was the recipient of many attentions from her friends. In social circles as well as professionally she will be much missed, and while every good wish follows her to her new home, her friends are as one in the hope that she may soon return to her native country.

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in April, 1929, were 1,080. Seventy less than previous month.

## APPOINTMENTS

Misses Irene Byers, Margaret Floyd, Cora L. Russell to the staff of the Isolation Hospital, Toronto.

Miss Mabel Boyle (Grace Hospital, Toronto, 1918), to the staff of the Willard Fillmore Hospital, Buffalo, N.Y.

Miss Alice Bechtel (Kitchener-Waterloo General Hospital, 1928), as operating room supervisor at the Kitchener-Waterloo General Hospital.

Miss Thelma Sitler (Kitchener-Waterloo General Hospital, 1928), as supervisor, at the Kitchener-Waterloo General Hospital.

Miss Esther Cunningham (Toronto Western Hospital, 1919), to operating room supervisor, Toronto Western Hospital.

Miss Mary Thomas (Toronto Western Hospital, 1919), formerly supervisor, Men's Surgical Division, has accepted the position as assistant supervisor of operating room, Toronto Western Hospital.

Miss Edith Bolton (Toronto Western Hospital, 1928), to Private Wards, Toronto Western Hospital.

Miss Mabel Coutts (Toronto Western Hospital, 1928), to Women's Medical Division, Toronto Western Hospital.

Miss Eileen Stowe (Toronto Western Hospital, 1928), to Ear, Nose and Throat Operating Room, Toronto Western Hospital.

Miss Myrtle Hamilton (Toronto Western Hospital, 1928), to assistant supervisor in Out-Patients' Department, Toronto Western Hospital.

The Registered Nurses Association of Ontario and the Toronto Overseas Nurses Club gave a dinner in honour of Matron-in-Chief Hartley on her appointment to the position of matron-in-chief of hospitals of the Federal Department of Pensions and National Health, on Friday, March 22nd, at the King Edward Hotel, Toronto. Miss Emory, president of the R.N.A.O. presided. Miss Ethel Greenwood, president of the Toronto Overseas Nurses Club, proposed the toast to the guest of honour. Greetings from the City of Brantford were brought and read by Miss Muriel McKee; from Miss Hartley's home district, No. 2, were brought by Miss Buck. Miss Smellie and Miss Rayside also spoke for Districts 8, 10 and 4.

## DISTRICT 1

GENERAL HOSPITAL, CHATHAM: The student nurses of the hospital entertained the 1929 graduating class and their friends, at a delightful masquerade on March 29th. The rooms of the Nurses Residence were attractive with St. Patrick's decorations.

A literary club under the guidance of Mr. Chas. E. Beeston has been organized for the student nurses.

The annual banquet of the Alumnae Association was held at the Garner Hotel on March 4th, with fifty-eight members present. Miss Grace Fairley, of London,

was the guest of honour, and delighted all present with a very interesting address on the responsibility of the nurse to her Alumnae and provincial association.

A very successful affair of March 22nd was the bridge sponsored by the Alumnae Association at the Nurses Residence. The many guests were received by Miss Campbell, superintendent, and Miss Tinney, president of the Association.

## DISTRICT 2

The regular quarterly meeting of the Registered Nurses Association of Ontario, District No. 2, held at the Galt General Hospital, was a record one, about 70 nurses being present. Representatives from Owen Sound, Guelph, Woodstock, Simcoe, Paris, Brantford and Galt were in attendance.

Miss Buck, Simcoe, the president, appealed to those nurses who have not yet linked up with the registered nurses to do so at the earliest opportunity, as through it, they are automatically members of the Canadian Nurses Association and the International Council of Nurses.

The speakers included Dr. Ward Woolner, Ayr, who spoke on the necessary care of mothers and babies in isolated districts; Mrs. Mitchell, on the opportunities of the public health nurse; Miss Davidson, on the benefit of "The Canadian Nurse" to nurses in general, and to the private duty nurses in particular.

KITCHENER-WATERLOO GRADUATE NURSES ASSOCIATION: The following programme has been arranged for their regular monthly meetings: Venereal diseases; Recent progress in Tuberculosis treatment in Europe; Nursing care in nervous diseases; Pediatrics; Gastro-Intestinal diseases; Anaemia. Also one garden party.

## DISTRICT 4

GENERAL HOSPITAL ALUMNAE ASSOCIATION HAMILTON: Misses Mae Wright and Ella Parsons (1928), spent Easter week at their respective homes returning to New York on April 7th.

Miss Jessie Jackson (1923), has left the Victorian Order of Nurses, and is doing private duty in the city.

Miss Black is again confined to the hospital, and is improving slowly.

Miss K. Campbell (1921), is in Sacramento, Cal.

Misses Doreen Jones (1926), Aileen Strachan (1927), and Thelma Ronson (1927), have returned from Albany, N.Y.

Miss Hilda Ayerst (1920), is in charge of a hospital in Kapuskasing, Ont.

Mr. and Mrs. Jas. Tarlton (Kathleen Peart, 1919), are living in Montreal.

Mrs. Flynn (Miss Tobias, 1909), has been holidaying in Hamilton.

Miss Ethel Roger (1926), is doing private duty in Cleveland.

Miss H. Brecken (1924), is at St. Luke's Hospital, N.Y.

Mrs. H. Cober and Miss E. Keffer (1927), are in Mt. McGregor, N.Y.



Miss L. Hack (1922), left for an extended holiday in Vancouver.

Misses W. Jennings (1920), and E. Lealess (1925), are in Hackensack, N.Y.

Miss F. Mackie (1924), is in Hempstead, N.Y.

Misses Anita Parks and Wanda Rogers (1924), are in Newark, N.J.

Mrs. Frank Elliott (May Campbell, 1917), is recovering after an illness of five weeks.

Miss Inez Fidlín (1927), has been in Texas for the past few months.

Miss Hazel Tilling (1925), has returned to Toronto for a holiday.

#### DISTRICT 5

**WESTERN HOSPITAL, TORONTO:** Miss Lowe (1915), supervisor of the operating room, recently tendered her resignation. Previous to her leaving the hospital, several social functions were given in her honour. Miss Ellis gave a tea in the Nurses Residence, which was well attended by the staff doctors and graduates. Miss Lowe was the recipient of a handsome gold wrist watch from the Medical and Surgical Staff doctors as an appreciation of her untiring efforts during her time of office in the hospital.

Miss Jessie Douglas (1919), is ill, her friends hope for a speedy recovery.

Misses Edna Hewitt and Ballantyne left on January 15th for New York, where they are engaged in private duty nursing.

Mrs. Smith, of North Carolina (Ruth Westlead, 1918), is spending a few weeks in Toronto.

Miss Doris Stinson (1928), is taking a post-graduate course in operating room technique at Johns Hopkins Hospital, Baltimore.

Miss Laura McDougall (1918), is spending a three months' holiday in Miami, Florida.

Miss G. Ryde (1921), formerly supervisor in the Out-Patients' Department has accepted a position in New York.

The annual dance of the Alumnae Association was held February 11th in the King Edward Hotel. About 300 guests were received by Mrs. Godfrey, Miss Ellis, Miss Wiggins and Miss Beamish. Excellent music was provided by Romanelli's orchestra.

**HOSPITAL FOR SICK CHILDREN, TORONTO:** Miss Kathleen Panton, former superintendent of the Hospital for Sick Children, has returned to her home in Milton, after an operation for thyroidectomy.

The sympathy of the Alumnae is extended to their president, Miss Hazel Hughes, in the loss of her mother.

**GENERAL HOSPITAL, TORONTO:** Miss Meta Greutzner (1923), has spent the last two months in California.

Miss Adelaide Lash Miller (1927), and her sister have gone to Japan for six months.

All graduates of the Toronto General Hospital are reminded that the annual dinner, given in honour of the graduating Class of 1929, will be held in Hart House, on May 20th, at 7.45 p.m.

**GRANT MACDONALD TRAINING SCHOOL, TORONTO:** The Alumnae held a dance and bridge party on March 19th in the Nurses Residence. The ball room was prettily decorated with balloons and flowers. About 250 guests were present.

#### DISTRICT 8

**OTTAWA:** Ottawa graduate nurses will be hostesses to the members of the Grand Council of the International Council of Nurses when they visit Ottawa on July 3rd. Tentative plans include a visit to the Parliament Buildings and the hospitals; luncheon given by the Victorian Order of Nurses of Canada; drive around the city; visit to Government House, and banquet at the Chateau Laurier, given by the Ottawa nurses.

At the R.N.A.O. meeting in Kingston, April 4th, 5th and 6th, there were twenty-four nurses present from Ottawa: two Reverend Sisters represented Ottawa General Hospital; Central Registry sent five nurses; St. Luke's Hospital Alumnae sent one; Lady Stanley Institute Alumnae, four; Ottawa General Hospital Alumnae, one; Royal Ottawa Sanatorium, one; Ottawa Civic Hospital, five; Metropolitan Life Insurance Company, one; Victorian Order of Nurses, four.

**CIVIC HOSPITAL, OTTAWA:** The Alumnae Association was organized recently. The officers for 1929 are: President, Miss Morna Young; First Vice-President, Miss Evelyn Pepper; Second Vice-President, Miss Margaret Hanna; Recording Secretary, Miss G. Wilson; Corresponding Secretary, Miss G. Moloney; Treasurer, Miss W. Gemmill; Board of Directors, Misses Mussell, Moxley, Margaret Wilson, Edna Osborne.

**A.A. LADY STANLEY INSTITUTE, OTTAWA:** The regular monthly meeting of the Lady Stanley Institute Alumnae was held at the home of Mrs. Charles Post. Considerable business was transacted, and arrangements made for a bridge to be held at the home of Mrs. W. G. Caven on April 17th. Refreshments were served at the close of the meeting.

The Alumnae held a rummage sale on March 2nd. It was well patronized, and brought very gratifying results.

#### DISTRICT 10

The regularly monthly meeting of the Registered Nurses Association of District No. 10, met at the McKellar General Hospital at Fort William, with a large attendance. The senior class of the McKellar General Hospital were the guests of the evening, and, after the conclusion of routine business, Miss P. L. Morrison, superintendent of the hospital, gave a most interesting lecture on the "History of Nursing," illustrating her fascinating discourse with a magnificent set of lantern slides. Plans were also completed for a play, that was produced during the second week of April. The evening closed with a most enjoyable social time.

On the evening of March 26th, a charmingly arranged bridge was held at the home of Mrs. H. McCartney, Fort William, when the

members of the McKellar General Hospital Alumnae were the guests. Tea was poured by the Alumnae executive, and assisting them were Miss Jessie McLaren and Miss Adele Taylor.

Miss Vera Lovelace was the official representative of District No. 10, R.N.A.O., at the Annual Convention held at Kingston, April 4th to 6th.

Dr. Griffiths Binning, who was for one year interne at the McKellar General Hospital, Fort William, has been appointed medical director of the Saskatoon schools by the Board of Education of that city. Dr. Binning graduated from the University of Toronto in 1923, and after one year at the McKellar General Hospital, he spent over a year and a half in the Hospital for Sick Children, Toronto, followed by some months in a similar hospital at St. Louis, Mo. In his new position, Dr. Binning will have charge of the medical inspection of 7,000 school children.

### QUEBEC

**SHERBROOKE HOSPITAL:** The annual graduation exercises held in the Nurses Home on April 5th was a most interesting and delightful event. Presiding were Mr. W. E. Paton, president of the hospital; Mr. D. J. Salls, chairman of the Executive Committee; Miss Helen S. Buck, superintendent of the hospital; Rev. Dr. W. S. Lemen. The president spoke briefly congratulating the graduates. Mr. Salls referred to the hospital and its work. The presentation of diplomas and pins was made by Miss Buck and Mr. Paton. Then the graduates repeated the Florence Nightingale pledge.

The graduates were: The Misses Glendolyn Farley, Anne Lander, Lucy A. Drew, Eileen Gondron, Gertrude W. Gibson, Myrtle Wallace, Ruby Spaulding, Maude E. Coles, Maryette Davis, Mildred L. Baldwin, May D. Ashford, Marjorie Foley and Kathleen Hatch.

The prize winners were: Miss Lucy Drew, Loyalty and Upholding the Training School; Miss Hatch, Practical Work; Miss Ashford, Highest Marks; Miss Baldwin, General Proficiency.

A dance was held later in the Nurses Home.

The friends of Misses Ailda Bernier and Kemphor, will be glad to learn that they are fully recovered from their recent illnesses, and are private nursing.

Friends of Miss Louise Foss will be glad to know that she has recovered from her serious auto accident.

Miss Mary Todd has resigned her position as night supervisor, succeeded by Miss Lucy Drew.

**WESTERN HOSPITAL, MONTREAL:** The Alumnae Association has had a book written, "The History of the Western Hospital, 1874-1924." Copies are to be had from Miss J. Craig.

Mrs. Bradshaw (Lydia McCleverty), spent a day at the Western Hospital while visiting in Montreal recently.

Alumnae members who recently visited Montreal are: Mrs. Bradshaw (Lydia McCleverty), Mrs. Lewis Smith (Ruby Tessier), of Moncton, N.B., Mrs. Gordon McNaughton (Ella Raymond), of Martin-town, Ont., and Miss Doris Stevens, of Sherbrooke, P.Q.

The sympathy of the members is extended to Miss L. Skinner, in the loss of her father; Miss Dogherty, in the loss of her mother; Miss Smeaton, in the loss of her mother; Miss Clader, in the loss of her mother.

**GENERAL HOSPITAL, MONTREAL:** Appointments: Miss F. Mathewson, on the Metabolism staff; Miss Henriksen, in charge of Ward "J;" Misses Percival, Barracough, and Ward, have joined the local Victorian Order staff.

Resignations: Miss R. Stericker, from position as Admitting Officer; Miss Monroe (1896), from Registration Office in the Out-Door Department, and has now charge of Brehmer Rest, St. Agathe, for a few months.

The monthly meeting was held March 8th in the Nurses Home. Dr. Rabinvitch gave a most interesting address on, "Diabetes among Children under Fifteen Years of Age." Refreshments were served by the social committee.

Many friends will be glad to hear that Miss E. Wales has recovered from an attack of typhoid fever, also that Miss M. Montgomery has left the hospital after her recent illness.

Miss Carpenter who has been confined to the hospital for the past three months is slowly recovering.

Miss Otterson, of San Francisco, is a patient in the hospital.

After an illness of a few days' duration, Miss Iris C. Mallalieu, a recent graduate of the Montreal General Hospital Training School for Nurses, died from pneumonia. Miss Mallalieu, whose home was in Trinidad, was the daughter of the Rev. S. S. Malleliu and Mrs. Malleliu. While waiting to write her Registration Examinations, she was gaining some extra experience in operating room work, previous to her departure for Barbadoes, to take up a position as operating room supervisor in a hospital there.

**GRADUATE NURSES ASSOCIATION, MONTREAL:** The Association reports the passing of a very dear friend of the nurses, Mrs. Frank Burch, who was the first registrar of the Association, which was started in 1894, and carried on the registry for over twenty-five years. Owing to an accident in 1920, she had to resign. Mrs. Burch died in Halifax, Easter Sunday, March 31st, after a long illness. Burial was in Montreal. Misses Dunlop, Hill, Colley, Sait, H. DesBrisay, Fletcher, Francis and Campbell, attended the services representing the association.

**C.A.M.N.S.**

TORONTO: The social committee of the Overseas Nurses Club, under the convener-ship of Mrs. Arthur Scott (N.S. Mildred Clark), entertained at a successful progressive bridge party at Christie Street Hospital, on Monday, February 13th. Proceeds amounted to \$90.00. At the annual meeting this year, the sum of \$100.00 was voted towards the expenses of the Congress, International Council of Nurses, and the club is gratified at the result of the first effort to raise the amount.

Miss Ethel Greenwood, president, made an informal address to Miss Hartley, matron of the hospital, congratulating her on her recent appointment as principal matron of hospitals, Federal Department of Pensions and National Health, and presented a useful week-end bag on behalf of the club.

**VICTORIAN ORDER OF NURSES****APPOINTMENTS**

Miss Daisy Metcalfe, to Carleton Place, Ont.

Miss Lillian Rankin, to the staff in Cornwall, Ont.

Miss Mary Cochrane, temporarily to the staff in Lachine, P.Q.

**RESIGNATIONS**

Miss Helen Baggott from the staff, Winnipeg, Man., owing to ill health.

Miss Jessie Durrell from the staff at St. Catharines, Ont. Miss Durrell will relieve in Timmins temporarily for Miss Marjorie Stevens who has leave of absence.

Miss Isobel Norton, represented the Ottawa Victorian Order of Nurses at the Registered Nurses Association of Ontario at Kingston in April.

**BIRTHS, MARRIAGES AND DEATHS****BIRTHS**

CULVER—Recently, at Simeco, Ont., to Dr. and Mrs. Culver (Doris Medlen, Hamilton General Hospital, 1924), a daughter (still-born).

DAVEY—On April 3rd, 1929, at Sherbrooke, P.Q., to Mr. and Mrs. Wilfred W. Davey, a daughter.

EMERSON—On March 11th, 1929, at Orleans, Vt., to Mr. and Mrs. L. C. Emerson (Gladys Hall, Sherbrooke Hospital), a son (Wayne Buchanan).

HAMBLETT—On March 15, 1929, at Toronto, Ont., to Mr. and Mrs. Hamblett (Daisy Dench, Isolation Hospital, Toronto, 1926), a son.

HAYWARD—Recently, at Medicine Hat, Alta., to Mr. and Mrs. R. H. Hayward (M. G. McBean, Children's Hospital, 1916), a son.

HICKEY—On March 22nd, 1929, at Evanston, Illinois, to Mr. and Mrs. Harry Cornelius Hickey (Pauline Carroll, Montreal General Hospital, 1920), a daughter (Pamela Margarite).

HISTEAD—Recently, at Hamilton, Ont., to Mr. and Mrs. J. Histead (Ora Myles, Hamilton General Hospital, 1926), a son.

HOWELL—On March 25th, 1929, at Galt, to Dr. and Mrs. H. Howell (Lillian Murray, Toronto General Hospital, 1919), a daughter.

MARTIN—On April 2nd, 1929, at Toronto, to Dr. and Mrs. Wm. Martin (Pearl Beavis, Toronto General Hospital, 1918), a daughter.

ROBERTSON—On March 3rd, 1929, at Toronto, to Dr. and Mrs. Ross Robertson (Mary Higgenbottom, Toronto General Hospital, 1927), a son.

THOMAS—On February 17, 1929, at St. Stephens, N.B., to Mr. and Mrs. Allison Thomas (Bernice Stairs, Chipman Memorial Hospital), a son.

WEIR—On March 29th, 1929, at Toronto, to Mr. and Mrs. C. Weir (Ella Hogan, Toronto General Hospital, 1925), a daughter.

ZUMSTEIN—On February 17, 1929, at St. Catharines, Ont., to Dr. and Mrs. George T. Zumstein (Florence Cowley, Mack Training School), a daughter (Florence Paula Todd).

**MARRIAGES**

ACLAND—COUCH—In March, 1929, at Ottawa, Ont., Helen Couch (Ottawa Civic Hospital, 1926), to Dr. Earl Acland.

BLACK—COSBY—Recently, Donna Cosby of Welland (Mack Training School, St. Catharines, 1928), to Harold Black. At home, St. Catharines, Ont.

BURGHER—KENNEDY—On March 23rd, 1929, at Toronto, Ada Kennedy (Toronto General Hospital, 1918), to J. Burgher.

CLEMENTS—MONNERY—On February 19th, 1929, at New York, Bertha Lillian Monnery (Kingston General Hospital, 1928), to H. Carman Clements, N.Y.

MORSON—GILMOUR—On April 6th, 1929, at Toronto, Emo Gilmour (Toronto General Hospital, 1928), to Errol Morson.

OLSON—GARRETT—On March 29, 1929, at Piapot, Sask., Ethel Olson (Medicine Hat General Hospital, 1928), to Louis Garrett of Medicine Hat.

**CHRISTON—LEBLANC**—On April 17th, 1929, at Cornwall, Ont., Anna LeBlanc (Montreal General Hospital, 1927), to Edward Ney Smith Christon of Montreal.

**STEWART—BELLE**—On February 20th, 1929, at Sherbrooke, P.Q., Phyllis Belle (Sherbrooke Hospital, Sherbrooke, P.Q.), to Belford Stewart of Toronto. At home, Sherbrooke, P.Q.

**WILSON—GAYMAN**—Recently, at St. Catharines, Ont., Anna A. Gayman (Mack Training School, 1927), to Maurice Wilson.

## DEATHS

**DAVIS**—On February 7, 1929, at Toronto, Mrs. Davis (Faye Lang, Isolation Hospital, Toronto, 1927).

**EVANS**—On March 29th, at Hamilton, Ont., Ella J. Evans (Hamilton General Hospital, 1921), after a lingering illness.

**MALLALIEU**—On March 30th, 1929, at Montreal, P.Q., Iris C. Mallalieu (Montreal General Hospital, 1929).

**STEWART**—In February, 1929, at Thorold, Ont., Mrs. J. D. Stewart (Julia Bouteher, Mack Training School, St. Catharines, 1912).

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## THE CANADIAN NURSE

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## REGISTRATION of NURSES

PROVINCE OF ONTARIO

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An examination for the Registration of Nurses in the Province of Ontario will be held in May.

Application, forms, information regarding subjects of examination, and general information relating thereto, may be had upon written application to Miss A. M. Munn, Reg. N., Parliament Buildings, Toronto. No candidate will be considered for examination unless the complete application form, accompanied by the examination fee of \$5.00, is received by the Inspector, before May 10th, 1929.

Signed:

**A. M. MUNN, Reg. N.,**  
Inspector of Training Schools.

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Further particulars and application forms may be obtained from:—

**THE SUPERINTENDENT OF NURSES**  
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Graduates receive (\$10.00) ten dollars per month with full maintenance.

For further information address

**C. V. BARRETT, R.N.,**  
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For further information write to

**W. J. DUNLOP, Director,**  
University Extension,  
University of Toronto,  
TORONTO 5, ONTARIO.

The Canadian Council on Child Welfare recently announced that during the past winter, the Education and Recreation Division, Montreal Council of Social Agencies, organized a Recreation and Social Leadership Training Course. The material prepared for this course has now been bound together in pamphlet form, copies of which may be obtained at twenty-five cents each from Captain William Bowie, Chairman Recreation Division, Canadian Council on Child Welfare, 1421 Atwater Avenue, Montreal P.Q.

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### CONTENTS

### PAGE

THE VALUE OF PERIODIC HEALTH EXAMINATIONS -	<i>Dr. A. Grant Fleming</i>	283
HOSPITALS OF THE MONTREAL COUNCIL - - - - -		286
BIOGRAPHIES, GRAND COUNCIL, I.C.N. - - - - -		294
CONGENITAL ATELECTASIS - - - - -		296
REPORT ON THE POLIOMYELITIS EPIDEMIC IN MANITOBA, 1928 - - - - -		297
DEPARTMENT OF NURSING EDUCATION:		
TRAINING SCHOOL RECORDS IN SMALLER HOSPITALS -	<i>C. E. Guilloid</i>	298
MCGILL UNIVERSITY SCHOOL FOR GRADUATE NURSES - - - - -		301
DEPARTMENT OF PRIVATE DUTY NURSING:		
ECZEMA - - - - -	<i>Dr. Harold Orr</i>	303
NURSING CARE OF ECZEMA - - - - -	<i>Ethel English</i>	305
DEPARTMENT OF PUBLIC HEALTH NURSING:		
A SYSTEM OF SCHOOL MEDICAL INSPECTION (CONCLUDED) -	<i>Dr. F. S. Burke</i>	308
BOOK REVIEWS - - - - -		311
NOTES ON I.C.N. CONGRESS - - - - -		313
NEWS NOTES - - - - -		315
OFFICIAL DIRECTORY - - - - -		323



# The Value of Periodic Health Examinations\*

By A. GRANT FLEMING, M.B., Montreal

The desire to escape from sickness and to achieve health is not a new one. No man ever wished to suffer from disease, and history records how mankind has evaded and fought disease as best it knew how.

We are today in a very enviable position as compared with the ancients. We have the knowledge which, if we would use and apply it, could cut in half the amount of sickness that now occurs in our country, thus greatly reducing human suffering, and the needless expense and other undesirable companions of sickness. Our increase in knowledge has made us feel rather superior. We smile with pity upon those who believed in the supernatural cause of disease, in witchcraft, the healing power of the King's touch, the influence of the evil eye, and the relationship between the stars and disease. But are we superior? Could there be any greater ignorance, in the light of present-day knowledge, than that displayed by those who still deny that successful vaccination prevents smallpox, or who, if they do not deny it, fail to practise it, which amounts to the same thing. There are those who quibble also about the value of pasteurization as a means of making milk supplies safe. The present will assuredly seem absurd when it becomes historical.

In seeking an explanation to account for illness and death from preventable diseases and for the lack of health, we find that two of the chief factors are ignorance and laziness.

Health, it must be understood, implies not only freedom from disease,

but a one hundred per cent. development of the capacity of the individual. Doctor Donald B. Armstrong has defined health in these words:—"The vigorous, beautiful, smooth-running, efficient operation of mind and body, of the instincts and the will, in a harmony of purpose and accomplishment."

It is rather remarkable that so few attain complete health, when we consider that, beyond question, health is such a desirable possession—desirable, not in the sense that health in itself is an end in life, but rather because, as a condition of life, it makes possible achievements and happiness in work and play that without it are unobtainable. Health is therefore good both for the individual and for the community.

The modern public health movement grew out of a humane desire to lessen the human misery which had resulted from the industrial revolution. It was directed, at first, almost entirely to the improvement of living and working conditions—sanitation as we now call it. There were added later isolation and quarantine, i.e., the control of communicable diseases.

People, in general, will agree as to the need for pure water, for safe milk and pure food, and will even support the principle of quarantine, the latter, however, perhaps, with the mental reservation that it applies to the other man's home and family. In other words, we favour those measures which improve things for us, providing that they call for no personal effort. So it is that those health measures which ask for nothing from the individual, excepting money, for their provision and enforcement, come about and are car-

(\* Delivered at a public meeting of the Canadian Medical Association, Charlottetown, June 21, 1928.)

ried on successfully. After all, taxes for health work are just as painless as any other taxes.

This sort of community health work does a great deal to protect citizens from disease that is carried by milk, water and food, and it does control, to a considerable extent, the communicable diseases which are spread from one human being to another. It has limitations, however, and it makes very little contribution towards the positive ideal of health, the one hundred per cent. development of the physical and mental capacity.

Individual health depends essentially upon the individual's practice of what we call "personal hygiene." Even in our age of organization, we expect that we must consider our bath, our bed-time, and our open bed-room window as personal responsibilities. Modern inventions have given us conveniences that greatly assist and make reasonably easy the practice of personal hygiene. The opposition that followed the introduction of the first bath-tub on this continent, in Cincinnati in 1842, leads us to believe that bathing was not a very generally accepted practice. One can hardly doubt that since the bath-tub has become a common household fixture, its use has materially increased.

Children may practise hygiene because of parental discipline, or the competitive spirit of the group, as seen in such organizations as the Junior Red Cross.

As adults, we practise personal hygiene chiefly as an established habit carried from childhood, and continued, largely because we have found that it makes us more comfortable. We continue to raise our bed-room window at night, not in the interest of health, but because we have found that we are more comfortable, that we feel better in the morning after having slept in a well-ventilated room. We know that if we do not wash our hands before eating, we are uncomfortable during

the meal. This, I believe, is most encouraging. We may expect the majority of people to practise personal hygiene because they will like it, because it will make them feel more comfortable. I do not believe we can ever expect that any considerable number of persons will do things they do not like just for the good of their own health, still less for the good of others. Most of us are as self-centred as the man who, according to the old doggerel, prayed:—

"God bless me and my wife,  
Our John and his wife,  
Us four and no more. Amen."

There is given to us, in the periodic health examination, an opportunity to secure a larger percentage of health. The periodic health examination by the family physician offers something that is not to be secured in any other way.

There is no lack of general health advice. Such advice is good and is valuable within limitations. Its value is limited because it is general. Of those who read it, or who hear it, many fail to see or understand the personal implication or the need for personal application. While none of us denies the desirability of health, so long as we feel well, so long as we can continue to participate in our favourite pleasures, we are apt to think that such general health advice does not apply to us, but that it is intended for someone else.

It is desirable that everyone be accurately and fully informed concerning this most important subject of health. The value of such information depends upon its practice. One may know all about the human body, the causes of disease, and the maintenance of health, but unless this knowledge is put to work and made part of the daily life of the individual, it will be useless so far as protecting that individual is concerned. To know that fresh air and sunshine are good is only of academic interest to the person shut up in a dark room; it is of practical value

when the window is opened, or when he goes outside. This is a very obvious example, and yet it is one which we see every day. While their number is decreasing, there are still thousands of people in our country who sleep in bed-rooms with windows tightly closed, at least, in winter. There are still many who shut the sun out of their homes rather than fade a carpet, although all of these have doubtless heard of the value of fresh air and sunlight. Most of us are just as foolish with regard to some one or other of the rules of personal hygiene. In most cases, it is because we have not understood or appreciated why these rules must be applied to our individual life. We need to have this pointed out to us, we need to be periodically checked up on it, and that is exactly what the family physician will do in the periodic health examination.

There has been a great reduction in mortality during the past few years, with the result that the average expectancy of life has been markedly increased. But because the reduction in mortality has been chiefly in the younger age group, there has been but little increase in life expectancy for those of forty years of age. This has not happened by chance. It is for the one simple reason that health conditions amongst children have received a great deal of attention in most places, and the reduction in sickness and deaths amongst infants and children has been in proportion to the work done. Look back over the health record of any city, and you will see written in the vital statistics, a remarkable story. After a number of years with the same high infant death-rate comes a period of rapid decline. You seek for the reason and you find two things. First, the establishment of well-baby clinics where mothers are taught the care of their babies, and second, the safeguarding of the milk supply. The extent and rate of the reduction in

infant deaths depend upon the extent and thoroughness of these two efforts. This infant hygiene work is a striking example of the use of knowledge. It is available for any community but it must be used if lives are to be saved. Simply to know about it, to talk about it, means nothing in the saving of lives.

The insidious beginnings of disease are not recognized by the sufferer. They are allowed to progress to serious conditions before the need for medical care is evident. It is left to the layman to determine the need for such care. If every person were examined each year, the earliest signs of disease would be detected; it would be possible to recommend the early treatment which always offers the best chance for cure. If not for actual cure, at least the arrest of the progress of the condition. Many mothers understand this, and infants are taken to private physicians and to well-baby clinics when they are apparently well. In schools, the well child is examined. This is, of course, what the adult should do. When well, try to keep well!

Even at the present time, with all the general information that has been disseminated, the percentage of tuberculosis cases who come to their physician with the disease well-advanced is appalling. The cancer case loses his chance of cure because he has waited to decide that he needs medical advice. The heart case, because of delay in securing advice, loses the chance of early care which would permit, in many instances, of his leading a full, if somewhat restricted, life. There is a great deal of truth in the observation that the man who lives longest is the one who, early in life, discovers that he has some abnormality, and so lives a careful, hygienic life. Is it not reasonable to say that during the period when proper treatment offers so much the opportunity for revealing the need for such treatment should not be lost, and is it not

rather absurd to ask the layman to decide upon the need for treatment during the early period of disease, when it is most difficult to diagnose?

The discovery of defects or of early disease is, however, the lesser value of periodic health examinations. Although a large percentage of apparently well individuals will be found with physical defects that require treatment, with early symptoms of disease whose cure or arrest depends upon prompt action, it is the need for advice concerning the maintenance of health that is the more important point. There are very few who do not need personal advice in the matter of diet, exercise, rest and relaxation, elimination, and other phases of personal hygiene. There are few who might not have better health than they now possess. We are all different, and just what one needs, what another neglects, and what still another abuses, are the things that must be discovered

and regarding which advice must be given. This type of advice needs behind it the same scientific knowledge and thought as does the prescribing of remedies for the acutely ill.

The family physician, because of his knowledge of economic, social, and home conditions, and because confidence is reposed in him, is the best qualified for this service.

Amongst limited groups of adults, the need for, and the results of, periodic examinations have been proved. Life insurance companies have found it good business to pay for such examinations for their policy-holders. The opportunity is open to all to safeguard their lives, to attain greater efficiency, by securing for themselves a periodic health examination.

Make periodic health examinations an axiom of your lives!

(Reprinted from The Canadian Medical Association Journal, November, 1928.)

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## *The Hospitals of the Montreal Hospital Council*

The Montreal Hospital Council is an association of the superintendents of the hospitals of the city of Montreal. The following information relative to these hospitals may prove of some interest to nurses who are planning to attend the Congress of the International Council of Nurses, in Montreal, July 8-13, 1929.

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### **THE MONTREAL GENERAL HOSPITAL**

One hundred and ten years ago a voyage across the ocean was totally unlike what it is today. Instead of modern comfort the pioneers endured a long and tedious journey on sailing vessels, living in dingy quarters and under the obligation of providing their own food and bedding. Sickness was not uncommon and

ship fever and other debilitating diseases often compelled the settler to seek aid upon landing in the country of his adoption.

To give this assistance, the Ladies' Benevolent Society opened, in the year 1818, a house on Craig Street, two blocks east of St. Lawrence Main Street, where they could offer food, shelter and medical aid to any needy new-comers. They went a step further, thanks to the Governor-General of that time, and obtained through his assistance, some discarded army beds and bedding, with which they established a small hospital of twenty-four beds, the nucleus of the Montreal General Hospital.

In 1821 the present site was purchased and the hospital capacity increased to seventy-two beds.



In 1824 the Montreal Medical Institute was inaugurated in connection with the hospital. This was the first medical school in Canada, and the hospital is in the proud position of being the first hospital in Canada to admit medical students to the wards for clinical teaching. In 1928 the doctors of the hospital in attendance at the Medical Institute established what is now known as the Medical School of McGill University.

The consistently steady growth of Montreal made an increasing demand on the hospital's capacity, but the hospital authorities always rose

1883, marking another advance in hospital service, the Montreal General Hospital instituted the first ambulance service to be run in connection with a hospital in Canada.

The year 1890 saw the establishment of the Training School for Nurses, which, after being opened by the Governor-General and Lady Stanley, was placed under the direction of Miss Nora Livingston. In 1892 the surgical pavilion, composed of the Campbell Wing, the Greenshield Wing and the operating suite, were added to the hospital.

In 1897 the corner-stone of a



MONTREAL GENERAL HOSPITAL, MONTREAL

to the occasion, and in 1832, the Richardson Wing was erected in honour of the Honourable John Richardson. This increased the hospital capacity to 100 beds. In this wing was the old original "Ward Eleven," so frequently noticed in Osler's "Medicine." In 1848 the Reid Wing was added in honour of Chief Justice Reid, bringing the total bed capacity to one hundred and thirty. In 1867 a Contagious Diseases building, with a capacity of forty beds, for the treatment of small-pox, was erected. In 1874 the Moreland Wing was added in memory of Thomas Moreland.

The year 1877 is a memorable one in the annals of Canadian surgery. During this year the Lister method of antiseptic surgery was introduced by the late Sir Thomas Roddick. In

nurses' residence—known as the Jubilee Nursing Home—was laid by Lord Lister in the presence of a brilliant and distinguished assembly gathered in honour of this world-renowned scientist.

In 1909 the present pathological building was added, and in the same year the first Dental Clinic to be established in a general hospital became part of the institution, with six dental chairs. This department has shown steady progress, possessing fifty dental chairs with a separate wing of its own, and is now the dental clinic of the Dental Faculty of McGill University.

In 1911 the corner-stone of that imposing structure known as the new building was laid. His Excellency the Governor-General, Earl Grey, graciously officiated at this

notable function. The same year saw the establishment of the Social Service Department. In 1924, thanks to the generosity of several members of the Board of Management, a biochemical laboratory was opened at a cost of \$27,000.

In 1926 there was opened the splendid building of the new school and residence for nurses, with every accommodation for 210 nurses. The second floor is devoted solely to teaching purposes and contains class rooms, laboratories, demonstration rooms, etc.

And last, but not least, in the history of this old institution, there has been consummated recently, after a careful study of the hospital situation in the city, an agreement for five years, whereby the destinies of the Montreal General Hospital, now amalgamated with the Western Hospital and the Royal Victoria Hospital (now amalgamated with the Montreal Maternity Hospital) will be guided by a joint commission, composed of five members of the Board of Management of the Montreal General Hospital, five members of the Board of Management of the Royal Victoria Hospital, and one representative from McGill University. While each hospital will retain its own autonomy, this commission will have power to decide on the erection of new buildings, raising of campaign funds and their distribution and correlation for teaching purposes, of medical appointments of the individual hospitals in connection with McGill University.

The kindly members and friends of the Ladies' Benevolent Society builded better than they knew when they gave a beginning to the magnificent institution known far and wide as the Montreal General Hospital. With its long and incomparable record of surgical, medical and dental efficiency, the Montreal General Hospital holds an enviable position among the hospitals on the American Continent, and is today, as ever, in the forefront of the advance of medical science.

## HÔTEL DIEU OF MONTREAL

The Hotel Dieu is a general hospital under Catholic auspices where patients of all classes are admitted without distinction of race or creed. Its history is a lengthy one and hence is closely associated with that of Ville-Marie, now known as the city of Montreal. Jeanne Mance, the foundress, was a member of that expedition which, under the guidance of M. de Maisonneuve, left La Rochelle (France) in the June of 1641 to establish a colony on the island of Montreal, landing there on May 17, 1642.

Eager to dedicate herself to a work towards which she had sacrificed her all with the highest courage born only of God, Jeanne Mance set up in her own home a hospital destined to receive and care for wounded soldiers, sick colonists and Indians. In the year 1644 she transferred it to a simple wooden structure measuring about 60 feet by 24. This, properly speaking, was the first Hotel Dieu, and so it stood for fifty years, ministering with a kindly hand to the suffering ones who sought refuge at its humble threshold. At that time the population of Ville-Marie numbered only seventy settlers. To these Jeanne Mance devoted herself unstintingly, dreaming but of the future of her noble work for suffering humanity. The God of Charity did not forget. He granted to her the great joy of seeing those dreams become a big reality. In the summer of 1659 she brought from France three Nursing Nuns: Sister Judith Moreau de Bresoles, Sister Catherine Macé, and Sister Marie Maillet, canonically known as the Hospital Nuns of St. Joseph. These devoted missionaries, braving all obstacles and afire with sacrifice for Christ's afflicted ones, came from La Flèche in Anjou, where, some twenty-three years before, their Order had been founded by M. Jérôme La Royer de la Dauversière and Mother Marie de la Ferre. From the moment of their arrival in Ville-Marie, one

may follow, and not without an emotion intermingled with admiration, a parallel development of progress and charity.

Until the year of her death, 1673, Jeanne Mance governed the hospital with a devotion, a vigilance and a zeal conspicuous only in those who are being sacrificed on the altar of Charity. Since 1675 the institution has been under the direct supervision of the nuns. Thrice destroyed by fire, thrice the Hotel Dieu arose from its ashes and continued to be the only institution of its kind in Montreal until the opening of the General Hospital

tion a hospital, classed as "A," and justly so, by the American College of Surgeons. At present the Hotel Dieu has 300 beds, and statistics for 1927 show that 4,555 patients were treated and cared for during the course of that year.

It would be an omission inexcusable to omit in passing the calibre and acumen of its medical staff. Its doctors are men of lengthy experience and tried skill. They are chosen largely from the Faculty of Medicine of the University of Montreal, and this in itself is no mean asset to the efficiency of the institution.



HOTEL DIEU, MONTREAL

there in 1821. Transferred in the year 1861 from St. Paul Street to the north slope of Mount Royal, where it is at present located, the Hotel Dieu does not cease to give evidence of a noted development materially and scientifically.

The year 1901 saw the opening of the Nurses' School, which has in attendance today approximately one hundred pupils. The successive addition of its many wings, the organization of new laboratories and other medical departments, together with the perfecting of those already in existence, made it possible to keep abreast with the onrushing progress in modern science. The introduction of the most modern methods added to the tender care inspired by the charity of Christ made this institu-

The Hospital Nuns of St. Joseph are strictly a nursing Order and have twenty-four such institutions, nine of which are in France. In Canada there are: Montreal (Hotel Dieu and St. Mary's Memorial), Kingston, Tracadie, Chatham, Madawaska, Athabaska, Windsor, Campbellton and Cornwall.

The tiny acorn planted on Canadian soil three centuries ago by the saintly Jeanne Mance, and nurtured during that period by the tears of struggles, hardships and trials, has become a mighty oak under whose kindly branches the sick and the wearied of the masses may find care and rest. Verily, "Kindness has begotten kindness," and "Bread cast upon the waters" has come back, for God has thrice blessed the work!

### THE ROYAL VICTORIA HOSPITAL

The Royal Victoria Hospital, Pine Avenue, Montreal, owes its existence to the generosity and public spirit of two great men, Lord Mount Stephen and Lord Strathcona, who, in 1887, dedicated the original endowment of one million dollars to the commemoration of the Jubilee of Her Majesty Queen Victoria. The choice of a site fell on the present ideal location far above the city on the mountain side, overlooking the valley of the St. Lawrence. Building was begun in 1889,

Women's Clinic, which incorporated the old Montreal Maternity Hospital, began to function, with a capacity of 212 beds. This department, complete in itself, typifies all that is efficient in modern hospital construction and equipment.

The training school, of which Miss M. F. Hersey (President, Canadian Nurses Association) is superintendent, has been in existence since 1894. It offers a three-year course of training and has to its credit a thousand graduates. There are at present 224 pupil nurses and a staff of 67 grad-



ROYAL VICTORIA HOSPITAL, MONTREAL

and the first patients admitted in 1894, the hospital then accommodating 146 patients.

Since that time the hospital has shown tremendous progress, now having attained a capacity of 700 beds, exclusive of children's beds. A Nurses' Home was erected in 1907, the old quarters being required for patients' use and laboratories. Already this residence has been outgrown and temporary adjuncts are employed. A new wing was constructed on University Street in 1922 to meet the growing demands of the dispensary service. Here 67,702 patients were treated last year. In memory of his parents Mr. J. K. L. Ross erected the Ross Pavilion in 1916. This is a complete unit of six floors, accommodating 120 private patients. In 1926 the

uates, of whom four are full-time instructors. Affiliation is offered to many smaller schools whose services are not adequate to meet the present requirements of nursing education.

Not only is the Royal Victoria Hospital designed to meet the needs of the sick and afford training for nurses, but it carries on an extensive programme of research in all branches of bio-chemistry, pathology, and bacteriology. It is connected with the McGill Pathological Department by tunnel and is closely associated with its work.

The past expansion seems a good criterion of future developments, and it is expected that both hospital and training school will continue in their splendid service to the public and will add still more to an illustrious record.



### HÔPITAL NOTRE DAME, MONTREAL

In the ancestral home of the Seigniors of Varennes, a pretty village on the St. Lawrence River, was born on October 15, 1701, a child on whom God had special designs and who received at baptism the name of Marie Marguerite. When only seven years old her father died, leaving his widow and six children destitute. By successive trials and sufferings God was moulding the soul of Marie Marguerite for the sublime mission to which He destined her. Left a widow at the age of

lowing in her footsteps, extend their charity to all classes, rich and poor, irrespective of creed or nationality.

At present the daughters of Madame d'Youville minister to thousands of sufferers in twenty-one hospitals, where eight hundred pupil nurses are following a three years' course in their various training schools.

Just outside the city of Montreal stands a magnificent building called the "Creche," entirely up-to-date and equipped with all modern appliances. It shelters over seven hundred helpless and homeless little ones, un-



Hôpital Notre Dame, Montreal

28, after only eight years of married life, she struggled painfully to care for her two sons, who eventually became priests.

This duty fulfilled, Madame d'Youville gave herself with all her possessions to the service of the poor and destitute.

The heart of the foundress was open to all unfortunates who appealed to her: the aged, the orphan, and abandoned children, the infirm, the insane, incurables, cancer patients, epileptics, and even prisoners of war found shelter under her roof.

Thus began, in 1737, the Institute of the Grey Nuns in Montreal.

From this mustard seed has sprung an immense tree spreading its branches all over Canada and the United States, where her daughters, fol-

der six years of age, who, in most cases, are abandoned by the authors of their existence. Here they find a home where the flickering spark of life is tended with the utmost charity and devotion.

These little ones are placed in foster homes and legally adopted by the parents in as many cases as possible.

### ST. MARY'S HOSPITAL

St. Mary's Hospital, an English-speaking Catholic institution situated in the heart of the residential district of Montreal and occupying one of the most desirable sites on Dorchester Street West, adjoining the historical and picturesque estate of Lord Stratheona, was formally opened to the public on May 16th, 1924.

While the hospital is essentially an English-speaking one, its doors are open to all, irrespective of race or creed, and incidentally opens up a new field for the medical profession, especially the younger Catholic doctors.

The establishment of St. Mary's Hospital was simultaneous with the foundation of the first English Community of Nursing Sisters, the Religious Hospitaliers of St. Joseph, by whom it is operated, in conjunction with a board of directors, duly authorized by provincial charter, having also the approbation and sanction of the highest ecclesiastical authority. Many historical events and incidents form the background of this foundation, which will make most interesting history when compiled; its association with the work accomplished by Jeanne Mance, that noble and illustrious pioneer and colleague of the first Governor of the Colony, whose privilege it was to found the first hospital in 1642, and live in history as the first lay nurse in British North America.

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### HOMEOPATHIC HOSPITAL

The Homeopathic Hospital of Montreal was organized in 1894 when a brick building was purchased and converted into an attractive small hospital. The hospital was formally opened by the Lord Bishop of Montreal, in the presence of a large number of prominent citizens. In 1899 a Maternity Annex and Nurses' Home was built, largely through the generosity of the late Miss Annie Moodie.

In 1923 a site was purchased for a new hospital on Marlowe Avenue, Notre Dame de Grace Ward. In 1925 a campaign for building funds was undertaken, and over \$300,000 promised. In 1927 the present building was erected. It is fireproof, handsome in detail, compact, with every foot of space put to good use. The building is five stories, with ground basement

and sub-basement. Laundry, kitchen and dining-rooms are in the basement. The first floor is taken up with administration offices, x-ray department, class-rooms, doctors' library, laboratory, out-patient department.

At present the nurses are occupying the second floor. The third floor is entirely for maternity patients, and has its case room, with a separate sterilizing outfit. The fourth floor has private and semi-private rooms. On the fifth floor there are two very complete operating rooms, with accommodation for private and public patients.

Each floor has a diet kitchen, blanket warmers, utility rooms and every accessory that goes to add to the comfort and welfare of the patients. Each floor has a fine solarium, heated and properly equipped. The total capacity is 135 beds. A new nurses' home is contemplated. The hospital was officially opened on December 19th, 1927.

The Phillips Training School for Nurses in connection with the Homeopathic Hospital was established and open to students the same year as the opening of the hospital, and was given the name of its benefactress. Two nurses graduated in the class of 1896, and since then the school has steadily grown till the graduates now number one hundred and forty-four.

At present there are thirty students and fifteen probationers in the school. The school for nurses is fully registered and provides a very complete training in all branches of nursing.

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### CHILDREN'S MEMORIAL HOSPITAL

The Children's Memorial Hospital was founded in 1902 to perpetuate the memory of Queen Victoria. The Committee of Organization found temporary quarters in a residence on Guy Street. Five years later a new building was erected on Cedar Avenue, the present site of the hospi-

tal, and it has become a general hospital for children, having a capacity of one hundred and forty beds, with a daily average of one hundred and ten patients.

A special feature of the hospital is the pavilion system. On the spacious galleries of these pavilions the little patients get their full share of sunlight.

The children receive each day, bedside tuition in the "three R's" from a visiting teacher. Upon discharge, orthopaedic patients continue their studies at the School for Crippled Children, a development of this bedside teaching.

The hospital is associated with McGill University as one of the teaching schools, its specialties being paediatrics and orthopaedics.

There is a well-equipped dispensary where clinics cover every department of medicine and surgery, and the Social Service Department has proved most useful in the following up of the patients.

The School for Nurses was established in 1905. The affiliations for its students extend over a period of nine months, being with the Montreal General Hospital, the Royal Victoria Montreal Maternity Hospital, and the Alexandra Hospital, and the graduates are fully eligible for membership in the provincial association and in the C.N.A. Affiliation is also given to students of other schools, and post-graduate courses offered in paediatrics and orthopaedics. Miss Annie S. Kinder is superintendent of the School for Nurses.

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### MONTREAL ALEXANDRA HOSPITAL

The Montreal Alexandra Hospital for Infectious Diseases was built and opened for the reception of patients in 1906. The necessary funds were provided by means of private subscriptions and a grant from the city

of Montreal. The hospital was designed to care for the English-speaking citizens of Montreal, suffering from infectious diseases; another institution, the St. Paul's Hospital, being built simultaneously to care for the French-speaking population.

The hospital has always been managed by a board of governors appointed by the English hospitals of Montreal and under the supervision of the Civic Health Department. It was built originally to accommodate 120 patients, but later additions have raised the capacity to 150, which, owing to the rapid increase of the population of the city, has been over-taxed for the past few years, especially during the winter months.

The nursing at first was done by volunteers from general hospital training schools; later a training school was established, giving a one-year course in infectious diseases. In 1918, owing to the increased demand for special training in infectious diseases, the training school was abandoned, and affiliations were made with several hospitals in the city, and later with others outside throughout Canada, until at present the hospital is staffed by twelve graduates in charge of wards and instruction, and about thirty-three pupils from ten different affiliated hospitals coming for two months' course of training in infectious disease.

There is an average of 1,500 patients a year admitted to the hospital, which has been entirely renovated in the past ten years, a modern cubicle system having been installed throughout with special facilities for aseptic nursing and training of nurses and students.

The treatment of patients and medical arrangements are controlled by a board of doctors, appointed by the general hospitals of the city. Internes are from staffs of the other hospitals, coming to the Alexandra Hospital for three months' service in infectious disease work.

## CATHERINE BOOTH MOTHERS' HOSPITAL

The Catherine Booth Mothers' Hospital derives its name from the late founder's wife. During the three and a half years that have elapsed since opening the same, 1,500 adult patients and 1,400 babies have received care. This indicates something of the success which has been attained. As the demands are greater than can be fulfilled, it is hoped that an extension of the work will be possible.

It was thought that the hospital was too far from the central part of the city, but instead of difficulty in filling the beds it has been necessary to refuse cases where bookings for confinement have not been made two or three months ahead.

At present the hospital has a capacity of fifty beds, and service is rendered to private, semi-private and public patients. The supreme governing body is the Salvation Army of Toronto. Already one class of nurses has graduated, and it is hoped that five more nurses will receive diplomas in December. (1928—Ed.)

Other hospitals belonging to the Montreal Hospital Council are:

Hôpital Français, Hôpital de la Miséricorde, Hôpital du Sacre-Coeur, Hôpital Saint-Jean-de-Dieu, Hôpital Ste. Justine, Montreal Children's Hospital, Montreal Foundling and Baby Hospital, Shriners' Hospital for Crippled Children, The Women's General Hospital, and Verdun Protestant Hospital.

## Other Biographies

In the May issue there were published short biographical sketches of a number of members of the Grand Council, International Council of Nurses, 1929. Since then we have been fortunate in receiving notes on representatives from several other countries.

### BELGIUM

*Mlle. Jeanne Hellemans*, is director of St. Elisabeth School of Nursing, Malines, Belgium. She has been for a number of years the president of the National Federation of Belgian Nurses, and is equally popular among French and Flemish-speaking nurses. She is very interested in international work, and has attended all the meetings of the International Council of Nurses since Belgium was affiliated as a member in 1922.

### FRANCE

*Mademoiselle Chaptal*, president of the National Association of Trained Nurses of France, will be one of the most outstanding among nurses attending the Congress.

From early girlhood she has been deeply interested and active in social work. Following her training as a nurse she became the prime mover in establishing the first tuberculosis dispensary in the district of Plaisance, in Paris, in 1900. In the same district she shortly afterward started a well baby clinic, with pre-natal care emphasized from the very outset. Three years later she rented a tenement house in the district, had it properly

repaired, gas and water laid on, and let the small apartments to working class families with at least three children. This experiment was so successful that ten years later a number of houses had been bought and remodelled for occupation by similar families. In the same district, *Mademoiselle Chaptal* established a co-operative shop. Previously it had been practically impossible to purchase groceries or household supplies in the neighbourhood without also buying spirits of some kind. The co-operative shop was established with the deliberate intention of combating this evil.

While active as a social worker, *Mademoiselle Chaptal* continued her interest in nursing, and in 1905 she aided *Madame Taine* in establishing one of the first schools for nurses in France.

In 1909 *Mademoiselle Chaptal* built a hospital with eighty-six beds in Plaisance, the aim being to provide hospital accommodation for middle class people. This scheme was received with great interest by a number of important firms which were anxious to help their employees.

*Mademoiselle Chaptal's* activities during the war were tremendous and varied, and since then she has acted as the only woman member on a committee which reported on free medical assistance, resulting in hospitals under the control of the "Assistance Publique" being made available to middle class patients.

In 1921, she made a report on nursing and then was asked to assist in the drafting of a Nursing Decree for France, the Act being passed in June, 1922, and *Mademoiselle*



Chaptal appointed first vice-president of the Conseil de Perfectionnement des Ecoles d'Infirmieres au Ministère de L'Hygiene.

Only six schools of nursing were then recognized by the government, but as a result of a few years extensive travelling by Mademoiselle Chaptal, and the efforts of others, the number of accredited schools has increased to fifty-three.

In April, 1923, Mademoiselle Chaptal assisted in starting the French nursing magazine, and shortly afterward was the prime mover in the establishing of the National Association of Trained Nurses of France, which now has a membership of 1,100 members.

Mademoiselle Chaptal is a Chevalier de la Legion d'Honneur of France, and has received many marks of honour, the greatest of all being, perhaps, the work confided to her by her Government. Since the war she has been chairman of the "Commission de l'Enfance a l'Office public d'Hygiene sociale du Department de la Seine," and a member of the "Commission permanente de la Tuberculose au Ministère de l'Hygiene." In 1926, she was appointed substitute member for France on the "Advisory Commission for the Protection and Welfare of Children and Young People," of the League of Nations, and served in that capacity at its meetings in Geneva in 1927 and 1928.

In September, 1928, she was appointed commissioner of the international inquiry into the problem of children living in bad environment which is being made under the direction of the above Commission of the League. (Abridged from The I.C.N., October, 1928.)

*Mme Catherine d'Ornellas*, vice-president of the National Association of Trained Nurses of France; assistant general superintendent of the Order of St. Joseph de Cluny; state diploma registered nurse, decorated with the Legion of Honour. Has for twenty-three years been superintendent of the nursing service of the Hopital Pasteur (attached to the Pasteur Institute). This hospital for contagious diseases, although not very large, takes care of the interesting cases—including tropical diseases—used for research work at the Pasteur Institute.

*Mlle. M. Greiner*, assistant secretary of the National Association of Trained Nurses of France; was trained in the Rue Amyot School of Nursing in Paris; after having done war work for several years, she was appointed director, School for Child Welfare Nurses of the Medical School, University of Paris, when this institution was established in 1921, which position she still holds. Mlle. Greiner is one of the thirteen nurse members of the Council on Nursing Education under the Ministry of Hygiene.

*Mlle. Antoinette Hervey*, was trained at the Florence Nightingale School, Bordeaux, and has for a number of years held the position of director of the Visiting Nurses of the Department de la Seine-Inferieure, Rouen, one of the most progressive departments in regard to public health. Mlle. Hervey is

the French Member of the Public Health Committee of the International Council of Nurses.

*Mlle. Jeanne de Joannis*, secretary general of the National Association of Trained Nurses of France, director of the Rue Amyot School of Nursing (L'ecole Professionnelle d'Assistance aux Malades), technical adviser to the Central Nursing Bureau of the Ministry of Hygiene, and member of the Council on Nursing Education under the Ministry of Hygiene. Mlle. Joannis has an excellent professional education, having, besides taken her training in Paris in the Rue Amyot School and different other courses in France, studied in England, Germany and Switzerland. For her very prominent work in the Balkan States during the war she received a number of meritorious decorations from various countries. She is considered to be one of the greatest experts on nursing education in France, and is also very interested in private duty nursing, having started different undertakings in this sphere. She is the French member of the Private Duty Nursing Committee of the International Council of Nurses.

#### NORWAY

*Sister Bergljot Larsson*, founder and president of the Norwegian Association of Trained Nurses, took her training as a nurse at the Municipal Hospital, Oslo, then became nurse in charge of the children's wards at the same hospital. She founded the association of the Municipal Nurses, Oslo, took special training in fever-nursing at City Hospital, Edinburgh, worked as a nurse for one year at the Royal Infirmary, Edinburgh, to gain further experience in general nursing, and to study training and administration of schools of nursing. She has had experience as a private duty nurse in Oslo, and founded the Norwegian Association of Trained Nurses in September, 1912, and was asked to be the president, and also to take care of the administration of the different departments. Sister Bergljot Larsson is also the editor of "Sykepleien," the nursing journal, and leader of the post graduate courses for administrators and teachers at hospitals and schools of nurses, for public health, social and nutritional workers and dietitians.

Sister Bergljot Larssen is known as a lecturer and writer on different subjects. She has studied nursing methods and technique, schools of nurses, public health and social work, nursing organization, hospital building, technique and administration, etc., in several countries, and has attended International, Northern and National Congresses for nursing and public health.

She is the first vice-president of the Co-operation of the Nurses in the North, member of the central boards of the following associations: The Medical Association in Norway, of the Norwegian Association for Promoting Hygiene and Public Bathing, of the Children's Welfare Work, and of the Unpolitical Association of Women Voters. She is also a member of several committees

concerning nursing education, registration, housing conditions and building.

Sister Bergljot Larsson is an honorary member of the Association of Municipal Nurses in Oslo, The Swedish Nurses Association of 1910, and Nurses Association of Finland. In 1919 she received The King's Medal for Merit.

This year she is attending the International Hospital Congress at Atlantic City as the official delegate from Norway, and the International Congress of Nurses at Montreal, as the president of the Norwegian Association of Trained Nurses and the member of the committees of nursing education and of membership.

Sister Gunhild Marie Guttormsen graduated from Oslo Municipal Hospital in 1905, and has since then been associated with the same hospital. From 1915, she has been superintendent of the Out-Patient and Receiving Department.

Sister Maren Horn, nurse in charge of the operating theatre at the nursing home of the Drs. Jervell and Huitfeldt, first prepared herself as a teacher in athletics. In 1914, she took up nursing and graduated from the Red Cross School of Nurses, Oslo. Since that, she has been attached to the same school except for a short time as private duty nurse, and as nurse in charge at one of the places

for the interned German soldiers in Norway during the war.

Sister Harriet Platou, is a graduate of the Red Cross School in Oslo, 1911. For some years she did private duty nursing in Oslo. In 1913-1914 she was a member of the nursing staff of the Modum Bath Establishment. After a visit to the United States of America, where she studied nursing, Sister Harriet Platou, since 1917, has held a position at Mrs. Frolich's Children's Nursing Home, Oslo. At present she is on leave of absence, which she is spending in Canada.

Sister Andrea Arntzen, matron of the largest hospital in Northern Europe—Ullevaal Hospital, Oslo, containing about 2,000 beds. She is intensely interested in nursing education, and has done much to improve the training of nurses in Norway. She is a member of several committees of the Norwegian Nurses Association.

#### SCOTLAND

Mrs. Rebecca Strong, former matron of Glasgow Royal Infirmary, was the first to start a preparatory course in connection with a school of nursing (1893), she is still, although now in her late eighties, taking a very active part in professional life, and is among her other duties president of the Scottish Nurses Association (founded in 1909).

### *Congenital Atelectasis*

A patient, after being in labour three days, gave birth to a baby boy weighing 6 pounds 8 ounces. High forceps had to be applied, and the baby resuscitated by the usual methods. Oxygen inhalations were given for half an hour without result. An x-ray of the baby's chest was taken. Both lungs were found to be clear, but not well aerated. The baby's condition was diagnosed "congenital atelectasis with a very poor prognosis." The following treatment was started.

First 24 hours: (1) The baby's head was kept very low and external heat applied constantly. Atropine sulphate gr. 1/1500 was given hypodermically for respiratory failure and oxygen given by inhalation constantly. (2) 5% glucose in normal saline ounces one per rectum q.3.h. and position changed frequently.

On the third day the respiration became less laboured and gavages were started, 5% glucose with one ounce of saline and three drops of whiskey were given q.4.h. One ounce of saline rectally with three drops of whiskey were given q.3.h.

On the sixth day the baby started to cry for the first time. On the eighth day oxygen was discontinued and the following prescription given: Brandy, 4%; glucose 7½%; aqua ad. drams ten q.6.h.; alternating with: Protein milk powder, 2 tsp.; dextra maltose, 1 tsp.; distilled water drams ten q.6.h. This treatment was carried out by gavage.

On the thirteenth day the baby was given breast milk (ounces two, q.3.h. times 7 daily) by gavage.

On the sixteenth day the baby was put to the breast. It took one ounce, and was then given the other ounce by medicine dropper.

On the twentieth day the baby was nursing every three hours and doing very well. The birth weight was six pounds eight ounces. The lowest weight recorded was four pounds one ounce. Weight on discharge was seven pounds nine and a quarter ounces.

The baby is doing splendidly at home and is entirely breast fed.

(We are indebted to the School of Nursing, Ottawa General Hospital, for the foregoing interesting report.—Editor.)

## *Report of the Poliomyelitis Epidemic in Manitoba, 1928*

A report on the poliomyelitis epidemic in Manitoba in 1928, has recently been published at the request of the Minister of Health and Public Welfare by the Great West Life Assurance Company of Winnipeg. The report made by the Medical Research Committee of the University of Manitoba is drawn up under the following divisions:

1. The organization of the work concerned with the preparation and distribution of convalescent serum and the investigation of its action during the Manitoba epidemic of poliomyelitis, 1928.
  2. The distribution of cases in the Manitoba epidemic of poliomyelitis, July-October, 1928.
  3. The preparation of convalescent serum for the poliomyelitis epidemic in Winnipeg, 1928.
  4. The results of convalescent serum therapy in acute poliomyelitis in the Manitoba epidemic, 1928.
  5. Summary of symptomatology and laboratory findings in acute poliomyelitis in the Manitoba epidemic, 1928.
- There is also a brief appendix on the pathology of the epidemic.

The foreward to the report states in part:

"The reports show that during a period of four and one-half months, from July 1st to November 15th, there were 435 cases of infantile paralysis in the province. Of these 302 were in Winnipeg or its suburbs. The deaths numbered 37, being about  $8\frac{1}{2}$  per cent. of those who contracted the disease. The reports do not show how many there were out of the total 435 cases who entirely recovered or how many were left with residual paralysis.

"However, one of the reports does show a complete analysis of the results in 161 definite cases which were specially observed. Of these cases, 17 died, 54 were residually paralysed and 90 made complete recovery. Serum was administered to 74 of these patients in the preparalytic stage and of these none died while only five showed residual paralysis.

Where serum was not administered until after onset of paralysis, the ratios of death and residual paralysis were very high. The hope is expressed that of those showing some residual paralysis a number will fully recover in the near future.

"Unfortunately very little can be inferred from the reports as to the mode of transmission of the disease, whether by way of food, air or otherwise, but that the disease is transmitted from one individual to another by some medium or media is reasonably clear and it also seems safe to infer that the onset of the disease occurs from five to seven days after the patient has been exposed to contagion. A number of cases are reported where two members of the same family developed symptoms within a day or two of each other. In such cases it is probable that the patients did not contract the disease from one another, but from some source to which there had been a common exposure some days earlier.

"Until some further facts are known about infantile paralysis, until the contagion is better understood and the germ is isolated, the disease will continue to be a dreaded one. The comparative helplessness of parents to protect their children from exposure induces a period of great anxiety when the disease becomes epidemic in the community. However, the splendid results obtained from the use of serum, if administered in time, are most hopeful and reassuring. But with respect to infantile paralysis, as with all other diseases, the main thing is that there should be no neglect of early symptoms. If treatment is undertaken in time by a qualified physician a cure is very likely to ensue. The only safe rule for parents to follow, when an epidemic of any kind is prevalent, is to call in a physician as soon as any untoward symptoms are observed."

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.  
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

### *Training School Records in the Smaller Hospitals*

By C. E. GUILLOD, Superintendent, Maple Creek General Hospital, Maple Creek, Saskatchewan.

On account of the necessity of having training school records in the smaller schools that will entail the least expenditure of time, and at the same time give an accurate and comprehensive analysis of the student's practical and theoretical work, the following student's history card has been planned for use in the smaller training schools in Saskatchewan, three of which have adopted it.

The card has been designed so that the average number of patients nursed per day may be arrived at, and the services shown in training schools having affiliations. Also so that easy

reference may be made to the student's time on duty and to her health record.

It requires to be supplemented, of course, by forms showing detailed account of practical work, and showing monthly progress of the student in development of nursing qualities, and of her standing from an ethical point of view.

This record is only intended to show a complete summary of the student's record, practical work, theory and character, so that at the end of graduation her status and that of her training school may be judged.

#### STUDENT'S HISTORY RECORD

Name	Date of Birth
Address	Nationality
Name of Nearest Relative	Religion
Address of Nearest Relative	Previous Occupation
Preliminary Education	
Physical Examinations	
Physician	Address
Entered	Date
Graduated	E—90 to 100%; V.G.—80 to 90%;
Resigned or Dismissed	G—70 to 80%; F—60 to 70%;
	P—Below 60%.

#### QUALIFICATIONS:

Thoroughness	Conscientious	Punctuality
Adaptability	Interest	Quietness
Observance of Rules	Reliability	Demeanour
Executive Ability	Manner	Quickness
Attitude to Patient	Memory	Observation
Neatness (Personal)	Technique	Judgment
Neatness (Work)	Initiative	Accurate
Co-operative	Resourceful	Courteous
Deportment on Duty	Poise	Dignity
Deportment off Duty	Tact	Loyalty
Strong or Weak Points in Character		
Strong or Weak Points in Work		

#### STANDING IN PRACTICAL WORK      SPECIAL TRAINING      STANDING IN THEORY

Preliminary Term		Preliminary Term
First Year		First Year
Second Year		Second Year
Third Year		Third Year

#### REMARKS:

Employment After Graduation



SUBJECTS	INSTRUCTOR	NO. CLASSES AND LECTURES				Standing in Examinations
		Prelim.	1st Year	2nd Year	3rd Year	
Elem'try Nursing & Hous. Econ. Hygiene and Sanitation Chemistry Bacteriology Therapeutics and Solutions Ethics Charting Theory of Practical Nursing Biology and Embryology Anatomy and Physiology Materia Medica Dietetics Massage Bandaging and First Aid Psychology Oral Prophylaxis Diet in Disease History of Nursing Medical Disease Pathology and Urinalysis Surgery Obstetrics Gynecology Pediatrics Orthopedics Eye, Ear, Nose and Throat Skin Diseases Venereal Diseases Nervous and Mental Disorders Tuberculosis Communicable Diseases Field of Modern Nursing						

## INOCULATIONS, VACCINATIONS, TREATMENTS

Date Treatment Result Signature

DEPARTMENTS	Hospital	Ratio of Patients Per Day	TIME IN DAYS			TOTAL SERVICES	
			1st Year	2nd Year	3rd Year	Patients' Days	Average No. Days in Each Dept.
General: Medical							
Surgical							
Obstetrical Nursing							
Nursery							
Children							
Infectious							
Total							
Operating Room							
Obstetrical Room							
Laboratory							
Dispensary							
Diet Kitchen							
Medical							
Surgical							
Gynecological							
Orthopedic							
Eye, Ear, Nose and Throat							
Out-Patients and Social Service							
Children							
Communicable Diseases							
Tuberculosis							
Occupational Therapy							
Psychopathic							
Total							

Total for 3 Years

Vacation—1st Year  
 2nd Year  
 3rd Year

## RECORD OF TIME OFF DUTY

Date  
 Date  
 Date

Illness—Date

Diagnosis

No. Days

Absent

Cause

No. Days

Time made up—Total Number of Days

MONTH 19----	Department	SUMMARY OF REPORT OF PRACTICAL WORK First Year
19----		Second Year
19----		Third Year

## AFFILIATING STUDENT'S RECORD

Name	Date of Birth
Address	Nationality
Name of Nearest Relative	Religion
Address of Nearest Relative	Previous Occupation
Preliminary Education	
Physical Examination	

## Entered Training

Record of Standing	Practical Work	Theory
1st Year		
2nd Year		
Executive Ability		
General Proficiency		
Deportment		

## INOCULATIONS, VACCINATIONS, TREATMENTS

Date	Treatment	Result	Signature
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## AFFILIATIONS:

Hospital	Time	Services	Date
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Special Lectures 3rd Year:

## *McGill University School for Graduate Nurses Announcements*

The School for Graduate Nurses, McGill University, makes the following important announcements of the appointment of additional members to their teaching staff. The unusual qualifications and excellent preparation of each new member for her particular field makes it possible to broaden the scope of the curriculum offered and insures sound instruction and thorough preparation of all students attending the School.

**FOR THE PREPARATION OF TEACHERS FOR SCHOOLS OF NURSING.**—Emphasis will be placed upon three important aspects or branches: first, health education; second, formal classroom instruction; and third, clinical instruction. Miss Harmer will be ably assisted by Miss Marion Lindeburgh and Miss Eileen Flanagan, both newly appointed to the staff on a part-time basis, and also by the supervisors and instructors in the affiliated hospitals.

MISS MARION LINDEBURGH is a Canadian, who, before entering the profession of nursing, had eight years' experience in teaching. She graduated from the St. Luke's Hospital School of Nursing, New York, in 1916. Miss Lindeburgh's work as a student in nursing, both in theory and practice, was outstanding, and clearly indicated her fitness for positions of responsibility and leadership. Upon graduation she was appointed on the office staff as teacher and supervisor, in which capacities she fully justified the high expectations and confidence of her colleagues and her superintendent. Miss Lindeburgh later studied Health Education at Teachers' College, Columbia University, and left St. Luke's to become the Director of the Health Education Department of the Provincial Normal School at Regina, Saskatchewan, where, during the past six years, she has achieved a remarkable success in building up a constructive teaching and health education programme. Miss Lindeburgh

comes to McGill School for Graduate Nurses with the highest recommendations and the School is fortunate and happy to announce her appointment to its staff.

Miss Lindeburgh will assist with the formal teaching at the University and will be specially charged with that most important phase in the preparation of teachers through observation, participation and supervised practice teaching.

In addition, Miss Lindeburgh will teach and conduct a health education programme at the Royal Victoria Hospital School of Nursing, thus insuring health for the students and providing a demonstration and practice field in health education for all students in the McGill School for Graduate Nurses.

MISS EILEEN FLANAGAN, before entering the profession of nursing, completed two years in the Faculty of Arts, McGill University. She graduated from the Royal Victoria Hospital School of Nursing in 1923. Since graduation, Miss Flanagan has had a rather wide and varied clinical experience as head nurse, supervisor, and assistant in administration in the office of the above School of Nursing, her experience in supervision covering almost every service. For three years, Miss Flanagan was in charge of the Research Ward of the McGill University Clinic in the Royal Victoria Hospital. During that time she took an active part in all the research work conducted by the Medical School, showing a special capacity for this type of study. Her interest and success as a clinical teacher, her development of the case-study and other methods of teaching, her influence with the students, and her keen interest in the nursing care and general welfare of her patients all demonstrated her special fitness for the field of clinical teacher and supervisor. During the past year, Miss

Flanagan has completed the course for instructors at the McGill School for Graduate Nurses.

**FOR THE PREPARATION OF ADMINISTRATORS IN SCHOOLS OF NURSING.**

—Miss Kathleen Hill has been appointed on a part-time basis to take charge of the field work in administration. This will consist of a well-organized programme of weekly excursions with conferences providing for observation, participation and supervised practice in professional and educational administration. The excursions will be planned to give the future administrators of schools of nursing a broad and sympathetic understanding of the various fields of nursing in which their students may be engaged and for which they are to receive their basic preparation. The excursions will include not only hospitals and schools of nursing, but all the community health and welfare activities which, linked together, comprise the programme for the maintenance of health and the prevention and cure of disease.

Miss Hill, before entering the profession of nursing, spent two years in the University of New Brunswick and MacDonald College. She graduated from the Royal Victoria Hospital in 1922. Since then she has had excellent experience as teacher and supervisor in several hospitals. During the past year Miss Hill has taken the course in administration at the McGill School for Graduate Nurses. Miss Hill will also be an assistant in administration at the Royal Victoria Hospital. This dual position will be highly advantageous both to Miss Hill as a teacher and to her students in administration.

**FOR THE PREPARATION OF PUBLIC HEALTH WORKERS, TEACHERS AND SUPERVISORS.** The announcement of Miss Isabel Stewart Manson's appointment was made in the May Journal. Miss Manson will come to McGill at the beginning of the school year in

September. During the summer Miss Manson will continue her studies in public health at Teachers' College, New York, and will also visit other cities to study their public health and social welfare programmes.

**RESEARCH IN NURSING.**—It is generally recognized that if knowledge is to be advanced or progress made in any profession or field, time, thought and energy must be devoted to the study of the special problems in that field unhampered by the immediate tasks which have to be performed. In medicine, wonderful strides have been made, because there are many qualified workers giving part or all of their time to research. In nursing, there are few, if any, who have time or leisure or who can be given the time and resources for the study of special problems in nursing.

To make this possible at McGill School for Graduate Nurses a Fellowship has been granted by Dr. Chas. F. Martin, Dean of the Medical School and Acting Principal of the University, and awarded to Miss Eileen Flanagan. The field of study will be a selected ward in the Royal Victoria Hospital, and the study itself will be devoted to (1) the needs of the patients from the nursing standpoint; (2) the nursing knowledge and skill necessary to best meet these needs, and (3) the best methods of teaching the students, and (4) the administrative aspects of the nursing and educational programme. The aims are to insure a better understanding and nursing of patients, to build up the clinical courses of study, and the best methods of clinical teaching. The study will be under the direction of the School and will be demonstrated to students of the School interested in clinical teaching. The hearty interest and co-operation of the Faculties of the Medical School and of the School of Nursing of the Royal Victoria Hospital have been assured.

BERTHA HARMER, R.N., M.A.



## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
Miss THERESA O'ROURKE, 733 Arlington St., Winnipeg, Man.

### *Eczema*

By HAROLD ORR, O.B.E., M.B., D.P.H., Edmonton

In any discussion of eczema it is first of all necessary to define exactly what type of superficial catarrh of the skin one has in mind. Defined by Willan (quoted by his pupil, Bate-man) eczema consists of a circumscribed patch of closely set, pin-head sized, deeply formed vesicles, accompanied by itching and burning. At first there is very little inflammation at the bases of the vesicles, but this phase is of short duration, and in the fully developed patch there is redness and swelling.

A study of sections cut from such a patch at various stages of its evolution shows that the earliest change is a dilatation of superficial capillaries, with a pouring out of lymph from these vessels into the intercellular spaces of the epidermis. This causes spongiosis or oedema, and as the pressure increases the intercellular fibrils break, the cells are pushed aside, and a sterile vesicle is formed in the middle of the prickle-cell layer. This enlarges to the size of a pin-head and may rupture on the surface (weeping eczema). The process may at any time be checked, lymph being poured out of the capillaries in amounts insufficient to cause weeping on the surface and giving rise merely to oedema. This causes an increase in the rate of multiplication of the cells of the stratum germinativum, and may even cause mitosis in the prickle-cell layer, leading to thickening (acanthosis) and to a derangement of the process of keratinization (parakeratosis) which results in the formation of scales.

There is another type of inflammation of the skin resulting from a speci-

fic irritant, such as hair-dye or a plant. In this the inflammation is more diffuse and the vesicles more superficial, not all of one size, and frequently coalescing to form bullae. The trouble subsides as soon as the irritant is removed and only recurs on the exhibition of the specific irritant. This condition is labelled dermatitis. Etiologically, it differs from eczema in its specificity. There is an idiosyncrasy on the part of the individual. I have two patients, dentists, with an idiosyncrasy for novocain, in whom this drug always produces a dermatitis when it comes in contact with the skin, yet neither has ever had an inflammation of the skin from any other cause. This idiosyncrasy may be acquired or inborn. As an example of the acquired type, there is the photographer, who after many years in his profession, may suddenly develop an idiosyncrasy for metol or hydroquinon, and thereafter a dermatitis develops on every contact with the irritant. The natural idiosyncrasy for *Rhus toxicodendron* is inborn and so common as to be a racial characteristic.

In eczema there is no specificity. This type of patient has a susceptible skin which reacts in a definite way to any irritant; even scratching or rubbing being sufficient in most cases to produce the reaction. It must be admitted, however, that there are cases of occupational dermatitis clinically and histologically indistinguishable from eczema, and one may have to rely on the history. From eczema should be excluded, of course, such conditions as seborrhoeic dermatitis, due to Unna's bottle bacillus; and

ringworm of the extremities, due to an epidermophyton. These eruptions may closely simulate eczema, but belong to a different category.

The constitutional factor in the causation of eczema has been much dilated upon by many writers, and there are few chronic ailments which have escaped notice in this connection. Usually, they are referred to in general terms, such as "disturbances of the nervous system," "any systemic derangement affecting nutrition or excretion," "foei of infection," and so on, with little or no evidence to prove that any one of them is capable of producing eczema *per se*.

All will probably agree that some internal factor or factors are concerned in most cases. The perplexing feature is the fact that so many diverse internal causes are apparently capable of producing the eczematous reaction, or at least of causing in the skin a susceptibility to this type of reaction under the stimulus of external irritation. Probably this susceptibility is brought about by an anatomical change in the skin itself, and this opinion is based on the observation that xeroderma, or dry skin, is associated with the great majority of cases of eczema coming under observation. In the prairie provinces of Canada the relative humidity of the atmosphere is low and any tendency to dry skin is accentuated. It is not unusual for a patient who has been afflicted with eczema in the east to find, on taking up residence in the west, that the skin becomes noticeably dry, a feature not previously observed. People with normal skins are not troubled in this way in the west. It may be suggested that in the case of these persons the skin has perhaps always been deficient insofar as the sebaceous glands are concerned, but in a very minor degree. Now, precise information regarding the influence of the other systems of the body over the sebaceous glands is lacking, but it is believed, as pointed out by Reade, that the vegetative nervous system is

an important factor. This system consists of two parts, the sympathetic and the parasympathetic. A balance between the two produces physiological poise, or a co-ordination of metabolic activities, which is the normal state. It is believed that this is accomplished through the hormones of the ductless glands, which are under the control of the vegetative nervous system and influence various elements of the skin, such as the pigment, sweat-glands, sebaceous glands, hair and nails, and vasomotor tone. Dysfunction of this neuro-endocrinological mechanism arises in response to three varieties of stimuli: (1) metabolic; (2) toxic; and (3) psychic. It can thus be understood how it is possible for an element of the skin to be influenced in a particular way by a variety of primary causes, and it is suggested that the eczematous patient has a skin deficient in sebaceous gland function, and that this condition is brought about by dysfunction of the endocrinological system. There is here a fertile field for investigation, and, as our knowledge of endocrinology increases, no doubt our present-day conceptions, or misconceptions, of many dermatoses will be materially changed.

In the treatment of eczema, if there is weeping, it is useful to begin with the dilute liquor plumbi subacetatis, a few layers of gauze being laid on and kept saturated. In twenty-four to forty-eight hours White's crude coal tar ointment may be applied, a thick layer being plastered on and covered with a few layers of gauze. This should be renewed once daily, and it is well to avoid irritating the skin by attempting to remove all of the old ointment. At the end of from four to seven days the skin will probably be clear, and the ointment may be removed gently with olive oil. X-rays are very useful in the chronic scaly variety. Ultra-violet light should never be used in the treatment of acute eczema. It is useful as an adjunct, however, in the treatment of chronic dermatitis. Bearing in mind

the anatomical abnormality of the skin, if a recurrence is to be prevented, it is necessary to overcome the dryness of the skin, and for this purpose an ointment of 50 per cent. lanolin and 50 per cent. vaseline, with the addition of a little calamine, should be applied to the skin twice daily, and always after washing. Irritation, especially scratching, must be avoided, and special precautions must be taken at night, because most of the damage is done when the patient is dozing off to sleep or before he is completely awakened.

### Conclusions

1. Eczema is a type of skin reaction occurring in an abnormal skin as a result of irritation.

2. This abnormality may be produced by a variety of internal causes, acting probably through the parasympathetic system.

3. After the outbreak has been cured relapses may be largely prevented by the application of emollients, in an effort to overcome the abnormal dryness.

(The Canadian Medical Association Journal, November, 1928.)

## Nursing Care of Eczema

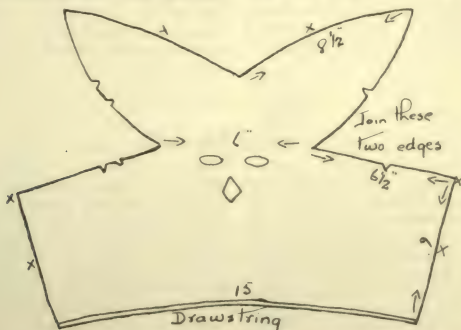
By ETHEL ENGLISH, Royal Alexandra Hospital, Edmonton

For the purposes of this paper, the term "eczema" is used in its broadest sense and to include not only circumscribed patchy eczema but the facial eczema of infants and the various types of dermatitis due to external irritation such as results from contact by susceptible persons with irritants, as hair dyes, dyed fur, certain plants as the primula or poison ivy, and from contact with irritants inseparable from certain occupations. While eczema used in this broad sense is perhaps the most common condition met with in a dermatological clinic, the opportunities for the student

nurse to observe and study it are limited because so few of these patients are admitted to hospital.

One of the most difficult types of the disease to handle is infantile facial eczema, and here it is necessary to adopt strict measures to prevent a recurrence, for even in an instant the child by one tear at its face can undo the work of a week.

In the local treatment, crude coal tar ointment is frequently used, and is applied smoothly and quite thickly with the aid of a wooden spatula, covered with a few layers of gauze and held in place by a well fitting



Ties about six inches long, should be attached at points marked "X."

mask, which is made (as per diagram) with four thicknesses of gauze, with exactly placed apertures for mouth, eyes and nose. The measurements given will be found to fit the average infant up to six or eight months of age, but slight variations may be necessary. The dressing is changed once daily, making no serious effort to remove the old ointment until after five or six days, when the eczema will have been cured, and the part is then gently cleansed with olive oil. From this point on, the success of the treatment depends almost entirely on close observance of the following points:

1. Scratching by the infant itself is perhaps the most common form of irritation to be guarded against and it is usually necessary to educate the child away from the scratching habit. The movement of the arms must be so restricted that the hands cannot be brought into contact with the face. This can be accomplished by means of a small splint extending from the axillae to the wrist, or by cardboard tubing placed over the child's arm and extending down to the finger tips. Celluloid or aluminum mitts are on the market and are useful.

2. The child must be kept in an equable temperature, preferably about 68 degrees F. Moving from a hot to a cold room and vice versa causes a flushing of the skin with its consequent itching and the urge to scratch.

3. Too bulky a diet also causes a flushing of the skin and should be avoided.

4. Only the softest of underwear should be used. Linen is to be desired, but if not obtainable, cotton or silk can be used. Woollens should not be worn in contact with the skin.

5. If the skin is dry and harsh, an emollient such as olive oil or cold cream should be used frequently and always after washing.

In dealing with eczema in adults, if there is weeping, the doctor in all probability will have prescribed some evaporating lotion, such as liquor plumbi subacetatis dilute. Ordinarily, liquor plumbi subacetatis fortis will be supplied, and from this strong solution the dilute is made by adding one dram to half a pint of distilled water, which should not be heated beyond room temperature. The use of distilled water is important, as with hard water the lead may be precipitated. The dressing must be kept constantly saturated, and in most cases this can be done by the patient himself. After one or two days of this treatment, the crude coal tar ointment will probably be used, and is applied in the same manner as previously described and is held in place by bandages or whatever manner is most suitable to the location.

Topical applications should be avoided for a few days prior to the use of x-rays, because many of these preparations, especially those containing metals, absorb rays which are later given off, thus intensifying the dose which the patient is intended to have.

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## *Maternal Mortality*

In the March, 1929, number of "The World's Health," published by the League of Red Cross Societies, Dr. Marie Brown, of Australia, writes an interesting article on "Maternal Morbidity and Mortality." "Child-birth today," says Dr. Brown, "has become a process fraught with pain and penalty, during which death and birth

go hand in hand more often than is seemly. Maternal mortality has lessened very little during the last twenty to thirty years. The ultimate causes of maternal morbidity and mortality are two and two only. They are economic stress and lack of education."



## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *A System of School Medical Inspection*

By F. S. BURKE, M.B., Director of Medical Services, Department of Public Health,  
Toronto.

(Concluded)

#### THE DIVISION OF NURSING

Perhaps no group is so intimately woven into the fabric of school medical inspection as the school nurses. It is they who are largely responsible for linking the school with the home. The school nurse's tactful approach to a mother often hastens the medical or surgical action that converts a defect into a termination. It is not a difficult task to find defects in the school child, nor is the finding of them particularly significant in the light of our present knowledge, but the termination of these defects is a vital problem, that largely falls to the nurse.

If the school medical officer fails to impress a mother with need for action, or if the mother is not present, the task must then become the nurse's. The adequacy of nurse follow-up is reflected in the percentage of terminations secured, not forgetting the quality of the work.

The health teaching in a school should centre around the nurse and she should be aided by the school physician. Furthermore, a school nurse's training should be such that she is equipped to understand a large part of the health teaching, thus keeping that important function where it seems to logically belong.

#### DENTAL SERVICES

This important function is carried out under the supervision of a Director, who has a staff of surveying and operative dentists, certain of the latter being extraction specialists.

The records of dental surveying and subsequent treatments and terminations are made entirely by the dental service, although the school nurse assists by arranging the dental appointments. In the summary of

the year's work, a few cases will be noted under No. 8, "Dental"; these are children who are referred to the dentist, because of some very abnormal condition urgently requiring attention.

#### MENTAL HYGIENE

This new science, as applied to school medical inspection, is directed by a psychiatrist, who has a staff of psychologists and social workers. When one considers what can be done for the mentally retarded and problem school child, if placed in a suitable "milieu," one is at a loss to account for any procrastination in attempting something in their behalf. Mental hygiene must be an integral part of every well thought out school medical programme.

*Records.* The question of records is one so full of controversial material that I approach it very cautiously. Records are necessary but time-consuming devices, generally disliked by those using them. Records should be as simple and few as possible and yet should have all the data that we may require. That sounds easy but in reality it is difficult of performance.

A card that follows a child through his school life and is so designed that it permits a succession of entries relating to both his physical status and his medical and surgical history seems the logical way to keep the record. The scheme that I am most familiar with has a record of academic career on one side of the card and the record of physical career on the other. This card is taken charge of by the educational authorities and forwarded from class to class and school to school. This of course immediately demands a standard card and a standard method of making entries of defects and the correction of defects.



TABLE I

DEFECTS ACCORDING TO NATURE OF DEFECT AND GRADE OF PUPIL  
School Medical Inspection—Toronto, 1927

Classification	Junior	Senior	Total
1. Vision.....	497	379	876
2. Hearing.....	138	93	231
3. Eye.....	103	5	154
4. Ear.....	56	34	90
5. Nasal.....	1211	388	1599
6. Tonsil.....	2168	734	2902
7. Anasmic Appearance.....	172	61	233
8. Dental.....	5	20	7
9. Digestive.....	10	1	11
10. Enlarged Glands.....	162	17	179
11. Skin.....	17	2	37
12. Orthopedic.....	67	24	9
13. Malnutrition.....	537	371	908
14. Pulmonary.....	44	12	56
16. Nervous.....	81	51	132
17. Thyroid.....	123	249	372
15. Cardiac.....	148	95	242
18. Other Defects.....	22	14	36
19. Mental Retardation.....	12	2	14
Total.....	5575	2598	8171

various districts had a tendency from time to time of injecting a spirit of competition into the recording of terminations that possibly made our results more colorful. Under the present scheme the entire work of deciding and recording is in the hands of the district medical officer who records daily his decisions under five heads coded as A, B, C, D, E.

Termination of defect by medical or surgical action..... A.

Termination of defect by natural means..... B.

Defect known to be under adequate medical and home care..... C.

Difference of medical opinion..... D.

No action obtained by us (i.e., lost address, left school, etc.)..... E.

Let us examine each singly—

A.—TERMINATION OF DEFECT BY MEDICAL OR SURGICAL ACTION.

This is one where the remedy has been complete, and constitutes 65.8 per cent of all terminations.

B.—TERMINATION OF DEFECT BY NATURAL MEANS.

This shows us how accurate was the summing up of the condition in the first instance. If the defect subsides with time to the point where it can no longer be considered as such, then how accurate was our diagnosis? This should eventually improve both our ability to diagnose and prognose. This group constitutes 13 per cent of our terminations.

C.—DEFECT UNDER ADEQUATE MEDICAL AND HOME CARE.

This is useful because it permits us to dispose of a type of defect, of which there are many and in which the school medical service has no further action. The future supervision of the case has been undertaken by a duly qualified medical practitioner, the only person whom we can recognize as responsible. 9.3 per cent of terminations were recorded in this group.





in the same year. In fact, the majority of defects terminated under A, medical or surgical action, are so terminated within three months of the finding of the defects. Taken over a series of years the total terminations do agree approximately with the total defects found.

**CONCLUSIONS.**—1. It is better to give thorough examinations at longer intervals with adequate follow-up by the nurses than superficial examinations yearly.

2. It is better for the physician to visit the school weekly, doing as much

as his time allows, than to work the school daily until finished and not revisit the school until the next term. This throws too much responsibility on the nurse, causing her at times to make decisions she should not be called upon to make.

3. The same type and extent of examination with similar records, should be demanded from all in order that the work may be comparable. Research studies by the school medical officer should not supplant or interfere with the routine examination.

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#### BOOK REVIEWS

**Nursing Care of Communicable Diseases**, by Mary Elizabeth Pillsbury, B.S., R.N., M.A.; published by J. B. Lippincott Company, Montreal. Price, \$3.50.

Few text books for nurses have been written on communicable diseases, and none that so completely and comprehensively covers the field of disease prevention, in the relation to communicable diseases, as does the text by Mary Elizabeth Pillsbury, published in January, 1929, by Lippincotts.

The work is divided into two parts. The first part deals with the prevention and control of communicable diseases. The second part with the nursing care of communicable diseases, in which the forty-eight diseases discussed are arranged alphabetically, making this text a very convenient reference book for the nurse.

Each disease is discussed under three heads:

(1) **Introduction:**

Dealing with the definition, history and occurrence.

(2) **Medical aspect:**

(a) The organism—its etiology, source of infection, route of transmission, period of communicability, laboratory diagnosis.

(b) **Course of the disease:**

Clinical picture, prognosis, complications and sequelae, treatment.

(c) **Measure for control:**

Early recognition and report, isolation and quarantine, immunization.

(3) **Nursing care:**

Special points, recognition of complications and sequelae, nursing procedures, measures for disease control in hospital and home.

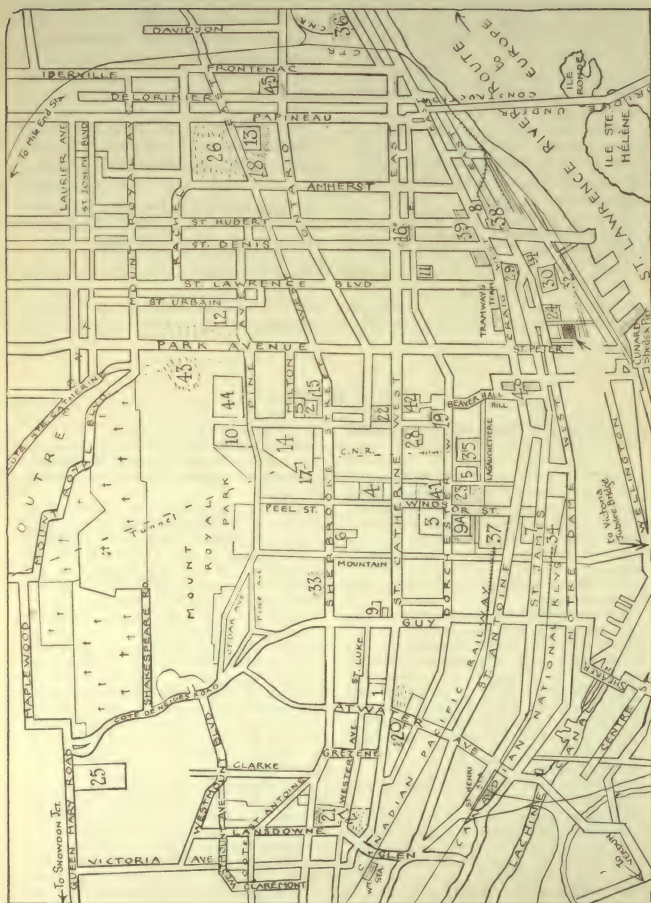
The teaching function of the nurse is strongly emphasized throughout in a way that is calculated to challenge her interest and co-operation, and awaken in her an appreciation of her responsibility in the control of communicable diseases, and the conservation of health generally.

Miss Pillsbury's text furnishes the nurse a readily available source of concise, definite and scientific information which must necessarily form the basis of her teaching equipment. The clarity and precision of detail with which all nursing and prophylactic procedures are described and illustrated, renders this work of great practical value to every nurse whether in her capacity of private duty nurse, supervisor or instructor.

Miss Pillsbury writes with dignity, and in a way that arrests and holds the attention of the reader. While her opinions and instructions are definite—she shows throughout a fine regard and appreciation for the work and opinion of others, thus adding strength to the appeal of her text.

I would thoroughly recommend the use of this book in all training schools, and feel that it would be of inestimable value to every public health nurse.

GERTRUDE P. GARVIN.



By Courtesy of The Cunard Line.

CITY OF MONTREAL

## *International Council of Nurses*

Under the distinguished patronage of their Excellencies the Governor-General of Canada and Viscountess Willingdon, the Sixth Congress of the International Council of Nurses will be held in Montreal from July 8 to 13. It is expected that nurses from thirty-five or more countries will attend, and delegates from nineteen countries, representing a membership of over 132,000 nurses, together with the Board of Directors, will make up the Grand Council, or voting body of the International Council of Nurses.

The opening business session of the Congress, held on Monday afternoon, July 8th, will be presided over by Miss Nina D. Gage, president of the Council, who will then give her presidential address. The formal opening of the Congress will take place on Monday evening, when addresses of welcome will be made by His Excellency, the Governor-General of Canada; the Archbishop of Montreal and Chancellor of the University of Montreal, Monseigneur George Gautier; the Premier of Quebec, Hon. L. A. Taschereau; the Mayor of Montreal, Camilien Houde; the Chancellor of McGill University, Mr. E. W. Beatty; the president of the Canadian Medical Association, Dr. A. T. Bazin; and the president of the Canadian Nurses Association, Miss Mabel Hersey.

Miss Nina D. Gage will reply to these addresses of welcome.

General sessions will be held Tuesday morning and evening, July 9th; Wednesday afternoon, July 10th; Thursday morning and evening, July 11th; Friday afternoon, July 12th; and Saturday morning and evening, July 13th.

Meetings of the three sections will be held concurrently on Tuesday and Thursday afternoons. Round Table Conferences are scheduled for Wednesday, Thursday and Friday mornings (See *The Canadian Nurse*, April, 1929, pages 197-200, for details of the Programme.)

All general sessions of the Congress will be held in the Forum. Section sessions will be held in the Montreal High School, the Windsor Hotel, and the Mount Royal Hotel. Sessions of the Grand Council (the Board of Directors and official delegates), and Round Tables will be in the High School.

Headquarters will be in the Montreal High School, University Street (above Sherbrooke St. West).

Registration will take place daily from 9 a.m. to 10 p.m., commencing Friday, July 5th, at Headquarters, where there will also be an Information Bureau and the Exhibits.

Films will be shown at 5.15 each day at Headquarters.

Special religious services are being arranged for Sunday, July 7th.

### SKETCH MAP OF CENTRAL MONTREAL

The numbers refer to position of numbers on map

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|--|---|
| 1. Forum: Auditorium for large General Sessions.   | 11. Montreal General Hospital.  |
| 2. Montreal High School: Congress Headquarters, Registration Office, Exhibits; meeting place for the Grand Council, the Nursing Education Section, and for special meetings of nurses from affiliated countries. | 12. Hotel Dieu.   |
| 3. Windsor Hotel: Private Duty Section meeting place.  | 13. Notre Dame Hospital.  |
| 4. Mount Royal Hotel: Public Health Section meeting place.   | 22. Christ Church Cathedral.  |
| 6. Ritz-Carlton Hotel: Where Grand Council will be in residence.   | 23. St. James' Cathedral.   |
| 9a. Y.W.C.A., Dorchester Street.   | 28. Post Office, next door to branch of Bank of Montreal, at University and St. Catherine Street. |
| 10. Royal Victoria Hospital.   | 31. Chateau de Ramezay.   |
|  | 32. Bonsecours Church and Market.   |
|  | 33. Art Gallery.  |
|  | 34. Bonaventure Station (C.N.R.)  |
|  | 35. Tunnel Station (C.N.R.), Laguachetiere Street West.   |
|  | 37. Windsor Street Station (C.P.R.)   |
|  | 38. Place Viger Station (C.P.R.)  |

## RE HOUSING:

The Committee on Arrangements for the Congress announces that there will be accommodation in convents for all nurses who have not yet made reservations for rooms. The price ranges from \$1.25 to \$2.25 per person per night, according to type of accommodation required. Beds are all single, some in lovely single rooms, others in dormitories, and prices include breakfast. Nurses are advised to write at once to secure their reservations, as time is growing short.

Nurses are requested not to make application for accommodation for others than nurses, as accommodation is limited.

Apply to Committee on Arrangements, International Council of Nurses, Royal Victoria Hospital, Montreal, P.Q.

## RE TRANSPORTATION:

The Canadian Passenger Association has authorized reduced fares on the Identification Certificate plan for all who will attend the I.C.N. in Montreal. Upon presentation of Identification Certificates round-trip tickets at fare and one-half will be issued.

Tickets purchased under the Identification Certificate Plan may, on payment of an additional three dollars, be routed via Canada Steamship Lines between Toronto or Kingston and Montreal.

Dates of sale are as follows:

	Dates of Sale	Return Limit
<b>Eastern Lines—</b>		
From east of and including Armstrong, Fort William, Sault Ste. Marie, Ont., and the St. Clair and Detroit Rivers....	July 4-10	July 20
<b>Western Lines—</b>		
From west of Armstrong and Fort William, and including points in Saskatchewan, Manitoba and Ontario.....	July 4-10	July 20
Points in Alberta.....	July 3-9	July 28
Points in British Columbia.....	July 2-8	July 21

and in addition round-trip tickets at fare and three-fifths, with thirty-day limit, will be also issued.

For western sections the usual summer rates may be less expensive and nurses are advised to consult local ticket agents for comparative rates and dates of sale.

All tickets must be validated at Montreal before return journey is commenced. Under the Identification Certificate Plan, validation means simply stamping of the ticket by the ticket agent.)

Identification Certificates may be obtained from the following provincial representatives:

Miss L. F. Fraser, Room 10, Eastern Trust Co. Bldg., Halifax, N.S.	Miss Matilda E. Fitzgerald, 279 Willard Ave., Toronto 9, Ontario.	Miss Helen Randal, 125 Vancouver Block, Vancouver, B.C.
Miss Maud E. Retallick, 262 Charlotte St., St. John, N.B.	Miss E. Carruthers, 753 Wolsley Ave., Winnipeg, Man.	Miss D. Mott, 110 18th Ave. West, Calgary, Alta.
Miss Anna Mair, Royal Edward Hospital, Charlottetown, P.E.I.	Miss E. E. Graham, Regina College, Regina, Sask.	Miss E. Armour, Jeffery Hale Hospital, Quebec, P.Q.

All nurses should reach Montreal by the morning of Monday, July 8th, as the first meeting will be at 2 p.m.

Post-Convention tours in Canada and U.S.A. are being arranged by Thos. Cook & Son, who will shortly issue an attractive folder. Canadian nurses may obtain these folders from the same provincial representatives who will issue the certificates.

### *Canadian Council on Child Welfare makes a new appointment*

Miss Dorothy Jones, of St. John, N.B., and a graduate of the School of Nursing, Montreal General Hospital, has been appointed as assistant secretary to the Canadian Council on Child Welfare. At the ninth annual meeting of the Council, by the adoption of the report of the Child Hygiene Section, the Council planned a three-year intensive educational campaign in the field of maternal infant welfare (see "The Canadian Nurse," January, 1929, p. 15).

Miss Jones will have charge of the development of this undertaking under the direction

of the Child Hygiene Committee of the Council. This committee includes representative public health workers throughout the Dominion, with Dr. J. T. Phair, of Toronto, as chairman.

Miss Jones has been a member of the staff of the Child Welfare Association of Montreal for the past two years, and is well qualified in every way for this new undertaking of the Canadian Council on Child Welfare, which has been made possible through assistance from the Canadian Life Insurance Officers' Association.



# News Notes

## ALBERTA

**CALGARY:** Nurses of Western Canada will regret to learn of the death of Miss Agnes Kelly, of Calgary, which occurred recently. Born in Ayrshire, Scotland, Miss Kelly graduated from the Glasgow Royal Infirmary, where she afterwards acted as matron. Later she studied fever nursing at Belvedere Hospital, and also district nursing. For the latter course she was awarded first prize and was enrolled with the Queen's Nurses in 1898. Miss Kelly lectured for a year under the Glasgow School Board, and also gave instruction on the feeding and management of children to women in some of the poorer districts of the city.

From Miss Kelly's arrival in Calgary she was interested in nursing and nurses' organizations. The local Graduate Nurses Association owes much to her efforts, and by this organization especially she will be greatly missed. Although so active in nursing, Miss Kelly also found time to assist in church and foreign missions undertakings.

**MEDICINE HAT:** The graduating exercises of the School of Nursing, Medicine Hat General Hospital, were held on April 23rd, in Fifth Avenue United Church. Those graduating were: Rosalie Shepherd, Anna Harrigan, Dorothy Simpson, Margaret Scott, Ellen Hatley, Margaret Rosoman, Elizabeth Sneddon, Edythe McTavish, and Mary Rowles.

## MANITOBA

**BRANDON:** The regular meeting of the Brandon Graduate Nurses Association was held at the home of Mrs. A. F. Campbell, when Miss Hatch, a returned missionary, gave a most interesting lecture on Medicine and Leprosy in India.

Mrs. R. Darrach (S. Persis Johnston), is improving slowly, after a serious illness.

Mrs. (Dr.) Baragar, is speedily recovering from a recent operation.

**GENERAL HOSPITAL, WINNIPEG:** Miss Mary Houston (1916), has accepted a position on the staff of the Provincial Board of Health, and is stationed in Brandon.

Miss Dora Peterson (1907), of Victoria, B.C., spent a short time in the city en route to Arbog, Manitoba, where her father is very ill.

Mrs. (Dr.) Irving (Miss Tuple, 1900), of Yorkton, Sask., and Mrs. G. P. Bawden (M. Irving, 1907), of Moose Jaw visited in Winnipeg during the Easter holidays.

Miss Florence Hooper (1927), left in April for Los Angeles, California.

Miss Edith Macey (1908), has returned to Winnipeg for the summer months.

Friends of Mrs. C. J. Bermack (Rose Fred, 1921), will be glad to know that she is improving from an auto accident; also that

Miss Josephine Morgan (1921), is convalescing after an operation.

Miss Pearl Christie (1927), has resigned from the staff of the Saskatoon City Hospital, and is doing private duty nursing in Winnipeg.

## NEW BRUNSWICK

**SAINT JOHN:** The annual meeting of the General Public Hospital Alumnae was held early in April, with Mrs. Fenwick McKelvey, first vice-president, in the chair. The annual reports told of a very successful year. The election of officers resulted as follows: president, Mrs. John H. Vaughan; vice-presidents, first, Mrs. Fenwick McKelvey; second, Miss Kathleen Lawson; secretary, Mrs. G. L. Dunlop; treasurer, Miss K. Holt; additional members of the executive, Mrs. R. McLaughlin, Mrs. H. H. McLellan and Miss Odessa McConnell.

**MONCTON:** The graduating exercises of the School of Nursing, Moncton Hospital, were held in the Assembly Hall, Aberdeen High School, on Monday evening, May 13th. Diplomas and medals were awarded to: Clara Bernice Lauder, Mary Edna Price, Helen Louise Sinnott, Annie Howard Gegan, Leonora Trueman Flemington, Frances Mary Kingston, Isabel Gray Young, Jessie Isobel Oliver, and Ida Winnifred Scott.

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in May, 1929, were 1,133. Fifty-three more than previous month.

## APPOINTMENTS

Miss Pauline Bissonnette (Ottawa General Hospital, 1928), as assistant supervisor of the operating room of the Ottawa General Hospital.

Miss Eileen O'Neil (Ottawa General Hospital, 1927), to the staff of the Joint Diseases Hospital, New York.

Miss Edyth Hopper, as assistant school nurse in Owen Sound.

Miss D. A. Fisher (Hospital for Sick Children, Toronto, 1925), night supervisor, and Miss Elizabeth Lewis (1925), is in charge, Baby Surgical Ward, Hospital for Sick Children.

Miss Jean Davidson, in charge Out-Patient Department; Miss M. McCormack, in charge, Private Wing; Miss Hilda Muir, in charge, Surgical Wards; and Miss Florence Kelfer, in charge, Medical Wards, Brantford General Hospital.

Miss Helen Anderson (Nicholl's Hospital, Peterboro, 1920), to the position of Public Health Nurse, in Peterboro.

## DISTRICT 2

**GENERAL HOSPITAL, BRANTFORD:** The regular meeting of the Alumnae was held in the Nurses Residence with Miss Dora Arnold

presiding. Dr. N. W. Bragg lectured on the before and after care for tonsillectomy. Arrangements were made for a bridge and euchre which was held most successfully on April 12th, when about 150 guests attended.

The many friends of Miss Hope Doveninger (1919), will regret to learn that she is ill in Los Angeles, California.

Mrs. Welsner (Louise Silver, 1922), Detroit, is visiting in the city for a short time.

OWEN SOUND: Mrs. Dudgeon, for the past three years assistant superintendent of the General and Marine Hospital, has resigned and is doing private duty nursing in the city.

Miss Johnston, former night supervisor of the General Hospital, is able to leave that institution after an appendectomy.

Miss Jean Currie has been appointed night supervisor of the General Hospital for the summer months.

#### DISTRICT 4

GENERAL HOSPITAL, HAMILTON: At the executive meeting of the Mutual Benefit Association of the Alumnae, \$341.00 was paid out in benefits.

Miss Evelyn Teeter (1927), was brought from New York by her sister, Miss Zeta Teeter (1924), to Hamilton General Hospital, where she underwent an operation for appendicitis. Her condition is improving.

Miss Hazel Tilling (1926), who has been in Winchester, Virginia, has returned and taken charge of Ward 4.

Miss Eva G. McNally (1921), has been very ill in Brandon General Hospital, where she holds the position of assistant superintendent and instructor. Miss McNally is now convalescing at her home at Butler, Man.

Miss Anna Coutts (1926), who has been in charge of Ward 7, intends taking the Public Health course, 1929-1930, at the University of Toronto.

Miss Jean Forsythe (1927), who has been in charge of Ward 4, is leaving to be married.

#### DISTRICT 5

GENERAL HOSPITAL, TORONTO: Miss Mildred Armstrong (1926), has accepted a position with the Standard Oil Co. and has left for Peru, South America.

Miss Mabel Sharp (1919), is relieving head nurse on Ward A, taking the place of Miss Alice Hunter, who is ill.

Miss Meta Gretzner (1923), has just returned to Toronto, having spent the winter in Florida and Cuba. On her way home she spent two weeks in New York with other Toronto General graduates.

Miss Ray Whittaker (1925), spent the winter in Miami.

The following interesting extracts are taken from letters written by Miss Cora Kilborn (1923), Women's Hospital, Shengtu, China.

"The weather is still cold, temperature 39 or 40 degrees outside, and the same in, when the doors are all left standing open as they are in the wards and all over the hospital. I'm afraid patients are not suffering from too many baths this cold weather,

and the nurses are padded up so thick, I know there will be a revelation as to their size when spring comes, and some of the layers begin to peel off! I am about the same too, one layer on top of another, but one has to keep warm in temperature so near to freezing. In our house we have grate fires where we need them, and that is certainly not all over the house. They are alright to look at but when it comes to warming you up they can't do both back and front at once, so one side suffers.

"Would you like to hear one instance of Chinese unrestrained temper and a certain custom they have. In the New Hospital they have a girl who is a sort of dietitian. One day a coolie in the kitchen got cross over something, and began throwing the dishes around, so, to straighten him out she went over and cuffed his ears. This was perfectly terrible, the man's dignity was gone altogether—to be slapped by a woman! If it had been a man it would have been alright, but to be slapped by a woman, he had lost face altogether. So to pacify him and soothe his troubled spirits, they allowed the other servants to dope him with red pepper and set off fire crackers. His face was thus restored and all was calm again."

HOSPITAL FOR SICK CHILDREN, TORONTO: The regular meeting of the Alumnae was held in the Residence on April 19th, the vice-president, Mrs. Langford, in the chair. An especially interesting lecture on Mental Hygiene was given by Mr. Bourdais, of the Canadian National Committee for Mental Hygiene, who illustrated his talk with a series of excellent lantern pictures, depicting the care of the patients in this type of work, both in Ontario and the United States. This closes the lectures for the year, and the programme committee is to be congratulated on the very excellent addresses that it has provided for the Alumnae during the winter, 1928-1929.

Miss Helen Howe has resigned as night supervisor.

Miss Thelma Irvine (1928), has resigned her position in the Rockefeller Hospital, and is doing private duty nursing in New York City.

#### DISTRICT 6

NICHOLL'S HOSPITAL, PETERBORO: The Alumnae entertained at bridge on April 17th, in honour of Mrs. Stanley Widdis, of Detroit (Daisy Stalker, 1922). The Nurses Residence was prettily decorated with spring flowers, the decorations being carried out in the hospital colours, purple and gold. During the evening, Mrs. Widdis, who had been on the hospital staff until shortly before her marriage was presented with a handsome silver tea service.

#### DISTRICT 8

OTTAWA: A well-attended meeting of District No. 8 was held May 1st in the new wing of the Ottawa General Hospital. Routine business and reports of standing

committees which occupied the first part of the morning were followed by demonstrations in bandaging, first aid, and practical uses of the metric system, given by several of the reverend sisters, with the help of a number of pupil nurses. Later in the morning Dr. Eugene Gaulin, urologist, explained new methods of sterilizing delicate instruments used in his work. A visit to several of the out-patient clinics concluded the programme till after luncheon. At the afternoon session, reports of the R.N.A.O. meeting at Kingston were given by the various delegates. Dr. J. L. Biggar's paper on, "The Cost of Sickness," was read by Miss Isobel McElroy. Dr. Biggar had expected to be present himself, but was called to Montreal at the last minute. Later a tour of the new wing of the hospital and the nurses residence was arranged.

Miss Margaret Farrell (Ottawa General Hospital, 1927), who has been assistant supervisor of the operating room at the Ottawa General Hospital since her graduation, has left to enter the convent of the Immaculate Conception. Miss Farrell will spend two years studying the Chinese language before proceeding to China.

Miss Minna MacLaren (St. Luke's Hospital, 1921), sails by the Empress of Scotland on May 7th, to tour the Continent for three months.

Miss Eleanor M. Charleson (St. Luke's Hospital), Canadian Immigration Principal Woman Officer for Scotland, is convalescing at the Ottawa Civic Hospital after a serious operation.

A successful year's work was recorded by the secretary of the Lady Stanley Institute Alumnae, Mrs. G. O. Skuce, at the annual meeting, which was held at the home of Mrs. Frank Campbell. Mrs. Skuce, who represented the Alumnae at the convention of the R.N.A.O. in Kingston, gave an interesting report of this meeting. The following officers were elected: president, Miss Mabel Stewart, Royal Ottawa Sanatorium; vice-president, Miss N. McNiece, Perley Home; secretary, Mrs. G. O. Skuce; treasurer, Miss C. Slinn; board of directors, Miss E. MacGibbon, Miss C. Slack, Miss E. McColl; representative to "The Canadian Nurse," Miss A. Ebbs; representatives to Central Registered Nurses Association, Miss A. Ebbs, and Miss Mary C. Slinn; press representative, Mrs. J. Waddell.

The Lady Stanley Institute Alumnae held an enjoyable bridge party at the home of Mrs. W. E. Caven recently.

#### DISTRICT 10

The regular monthly meeting of the Registered Nurses Association of Ontario, District No. 10, was held on April 4th, at the Nurses Home of the Port Arthur Railway, Marine and General Hospital. There was a large attendance of members, and a lengthy programme of business was completed. Final arrangements were made for the banquet which is to be held in the newly com-

pleted Royal Edward Hotel, at Fort William, on which occasion the Registered Nurses will entertain the superintendents and graduating classes of the three local hospitals, i.e., The McKellar-General Hospital, Fort William; St. Joseph's Hospital, Port Arthur; and the Port Arthur Railway, Marine and General Hospital. Further progress was made with the details of the proposed, "Pageant of the History of Nursing." At the close of the meeting, delightful refreshments were served by the nurses of the Port Arthur Railway, Marine and General Hospital.

The regular monthly meeting of the Alumnae of the McKellar-General Hospital, Fort William, was held on Tuesday, April 23rd, at the home of Mrs. F. Eberts, with a large attendance. The president, Mrs. F. W. Edwards, was in the chair. The routine business included the arrangements for a rummage sale to be held on May 18th. An interesting paper was read by Miss Vera Lovelace on, "The Value of the Banana in the Daily Diet." At the conclusion of the meeting, a social hour was enjoyed and refreshments served by the hostess.

The Alumnae of St. Joseph's General Hospital have held their first banquet in Port Arthur, and it is proposed to make the event an annual one. Twenty-six graduates were present, and among that number were nurses representing classes from 1906 to 1929, inclusive. The banquet was held in the new dining hall of the hospital, and the graduates were seated at an attractively arranged table. The hall was artistically decorated for the occasion with cut flowers. Prior to commencing dinner, Miss Anna Boucher, president of the Alumnae, spoke a few words of welcome to the graduates and urged that they be loyal to their school. A full programme of toasts, music and community singing accompanied the dinner. The toast to the King was proposed by Mrs. J. Teskey, to Alma Mater by Miss Irene Sheehan, to "Our Profession," by Miss Lois Carter, and to the sister nurses by Miss M. Flannagan. The musical programme included a parody, "Put on your old St. Joseph's bonnet with the black ribbon on it." The speaker of the evening was Mrs. Archie McIver, who drew some interesting comparisons between the practice of nursing today and that of some years ago. Miss Margaret Coghlan moved a vote of thanks to the Rev. Mother Aldegonde and the Sisters, through whose efforts it was possible to hold the banquet in the school from which all present had graduated. Following the singing of God Save the King, the regular business meeting was held in the lecture room of the hospital, at which Miss C. Nault presided.

A private room in the new wing of the St. Joseph's Hospital, Port Arthur, has just been completed for the use of sick nurses.

Miss Cecile Nault, St. Joseph's Hospital, Port Arthur, has left for Windsor to take up private nursing.

### QUEBEC

GENERAL HOSPITAL, MONTREAL: Appointments: Miss E. Hamilton, Out-Door Department, Woman's General Hospital; Miss Raeburn, Dr. H. Little's Office; Miss Belford, Floor Duty, Rockefeller Hospital, New York; Miss S. Hicks, Staff Operating Room, Montreal General Hospital; Miss Rheimer, Staff Out-Door Department, Montreal General Hospital; Miss D. Jones, member of the staff of Child Welfare Association of Montreal, to the position of Assistant Secretary to the Canadian Council on Child Welfare, Ottawa.

The many friends of Miss Lillian MacMartin, of St. Andrews, will be grieved to hear of her death, which occurred suddenly on April 8th at the Montreal General Hospital, while visiting in Montreal; also of Miss Janet Wainwright at the Hospital on May 3rd, of pneumonia, contracted while on duty. Miss MacMartin, though not doing active nursing, was helping her fellow workers in the church, socially, and especially in her home. Both Miss MacMartin and Miss Wainwright graduated in 1900, and their charming personality and sunny disposition won them many friends wherever they went. We feel that

"They are not dead, they have but passed

Beyond the mist that binds us all,  
Into the new and larger life  
Of that serene sphere."

The sympathy of the members is extended to Miss Carmen in the death of her mother; to Miss R. Hamilton in the death of her mother; and Miss McMurrick in the death of her brother.

WESTERN HOSPITAL, MONTREAL: The Alumnae held their annual dinner on April 24, 1929. The guests of the evening were Misses Hersey, Holt, Harmer and Ferguson. Toasts were proposed to the King, the Guests, Absent Members and the Alma Mater. The dinner was very well attended.

At the last monthly meeting of the Alumnae a very interesting illustrated talk was given by Mr. Dan McCowan, "A Naturalist in the Rocky Mountains," and was thoroughly enjoyed.

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: Miss F. Hummell (1927), is acting as ward supervisor for a few months.

Miss A. Sutherland (1925) has gone to Boston, where she is doing private duty work.

Miss E. Thompson (1927) has resigned from the staff of the Woman's General Hospital, and Miss D. McLaughlin (1929) has replaced her.

Miss A. Thompson (1926), who resigned as night supervisor at the C.M.H., has been succeeded by Miss E. Feader (1929).

Miss G. C. Bancroft (1927) has been granted six months' leave of absence following an operation for appendicitis, and is spending the summer abroad. Miss M. Flanders (1928) is acting as assistant instructor during Miss Bancroft's absence.

Miss R. Miller (1928) is doing relief work with the Victorian Order of Nurses.

The Alumnae has voted the sum of \$100.00 to the I.C.N., and this is being raised by different members of the Alumnae who are giving private bridge parties.

Miss G. Fitzgerald (1927) is on the staff of the Lady Northcliffe Hospital, Grand Falls, Nfld.

The graduating exercises were held on Friday, April, 26th the graduates being Misses A. Adlington, E. Feader, V. Schneider, R. Paterson, D. McLaughlin, B. Goobie, B. Cleary, V. Ledrew, R. Tinkiss, A. Creighton, M. Wilson. The prize winners were Miss Adlington and Miss Tinkiss. H. B. Cushing, M.D., was chairman. The Rev. Canon Gower-Rees gave the address to the graduates and Mrs. L. M. Lindsay presented the pins and diplomas. Tea was served. In the evening of the same day a very enjoyable dance was held.

HOMEOPATHIC HOSPITAL, MONTREAL: Miss D. Smith has returned from her trip to Bermuda.

Miss J. Coyle left in April for Scotland, where she will remain indefinitely.

The class of 1929 held a very pretty dance in the Nurses' Home recently, when a thoroughly enjoyable evening was spent.

The staff and graduates held a dance at Alexandra Hall, at which the graduating class was entertained.

JEFFERY HALE HOSPITAL, QUEBEC: The sympathy of the Alumnae is extended to Miss Armour, Lady Superintendent, in the loss of her mother, and to Miss Fischer in the loss of her father.

Miss Fischer has returned from a visit to relatives in England and is again doing private duty.

Miss Simms has left for a two months' visit to England and the Continent.

The 1929 Graduating Class and the Alumnae were entertained at tea by Miss Kinder on April 24th. The Alumnae chose this occasion to present the new graduates with a year's subscription to "The Canadian Nurse."

### VICTORIAN ORDER OF NURSES

#### APPOINTMENTS

Mrs. Florence Hart, formerly of the Victorian Order in Stratford, Ont., has been appointed public health nurse for the city of Stratford.

Miss Lillian Edmison (Nicholl's Hospital, Peterboro, 1926), who has recently taken a course in Public Health Nursing with the Victorian Order of Nurses, Montreal, has accepted a position with them.

#### C.A.M.N.S.

MONTREAL: At the May meeting of the Montreal Association of Overseas Nursing Sisters, it was decided that the Association would entertain the Nursing Sisters of The British Commonwealth attending the I.C.N. Congress, to a motor drive to St. Anne de Bellevue, and a lawn party at the D.S.C.R., on Wednesday, July 10th, 1929, from 3-7 p.m.



An invitation is extended to all ex-service nursing sisters.

Canadian nursing sisters who wish to accept this invitation are asked to notify the undersigned as soon as possible in order that the association may proceed with final arrangements.—(Mrs.) E. E. Petch, Secretary, 396 Olivier Avenue, Westmount, P.Q.

Deep regret is felt in the loss of our comrade Mrs. T. H. Titus, of Mayo, Yukon Territory.

Mrs. Titus (Elizabeth McDougal, Medicine Hat General Hospital), was an original member of No. 5, Canadian General Hospital, British Columbia. She saw service in Saloniki with that unit, and was invalided from there to England after contracting malaria.

In 1927, she had regained her health sufficiently to go to France, where she

joined No. 3, Canadian Stationary Hospital, at Doullens. Here she was awarded the Royal Red Cross, and afterwards was mentioned in despatches.

At the close of the war, she returned to Canada, and subsequently gave two years service with the D.S.C.R., Edmonton. The call of the frontier appealed to her and in 1921, she took charge of the hospital at Grand Prairie, Peace River, and afterward at Mayo, Y.T. She was married at Mayo, in October, 1925.

Besides her husband, she leaves to mourn her loss, two sisters and one brother, and many members of the C.A.M.C. who counted it a privilege to be called her friends.

Interment was made in the Masonic Cemetery, at Mayo, three returned soldiers and three Masons acting as pall-bearers.

—Edith Franks, Victoria, B.C.

### BIRTHS

CALVIN—On April 26th, 1929, at Toronto, to Mr. and Mrs. Calvin (Isabel Moore, Toronto General Hospital, 1925), a daughter.

CANE—On March 26th, 1929, at Arvida, Quebec, to Mr. and Mrs. Murray Cane (M. Feeney, Montreal General Hospital), a son.

CHESLEY—On April 8th, 1929, to Mr. and Mrs. Arthur Chesley (Beatrice Reid, General Public Hospital, St. John, N.B., 1920), a son, John Cooper Chesley.

EASTON—On April 15th, 1929, at Hamilton, Ont., to Mr. and Mrs. Russell Easton (Armeda Champ, Hamilton General Hospital, 1920), a son.

FRIPP—On January 31st, 1929, at Vancouver, B.C., to Mr. and Mrs. James Fripp (Kathleen Thorpe, Vancouver General Hospital, 1923), a son.

GRAY—On May 8th, 1929, at Toronto, to Dr. and Mrs. Harris Gray (Mary Anderson, Toronto General Hospital, 1926), a daughter.

HUTTON—On March 11th, 1929, at Vancouver, B.C., to Mr. and Mrs. Harold Hutton (Caroline Meredith, Vancouver General Hospital, 1918), a son.

O'DOWD—On April 18th, 1929, at Hamilton, Ont., to Mr. and Mrs. T. J. O'Dowd (Myrtle Hammill, Hamilton General Hospital, 1920), a son.

ROSS—On March 10th, 1929, at Vancouver, B.C., to Mr. and Mrs. Sim Ross (Nina Waldron, Vancouver General Hospital, 1925), a son.

SCOTT—On April 19th, 1929, at Grand Falls, Nfld., to Dr. and Mrs. Scott (A. M. McLeod, Montreal General Hospital), a daughter.

SKILLING—On March 26th, 1929, at Vancouver, B.C., to Mr. and Mrs. W. Skilling (Zella Doraty, Vancouver General Hospital, 1923), a daughter.

SPENCE—On April 1st, 1919, at Girvin, Sask., to Mr. and Mrs. John G. Spence (Mary Russell, Hamilton General Hospital, 1924), a son.

WALKER—On February 17th, 1929, at Penticton, B.C., to Dr. and Mrs. Roy Walker (Kathleen Robinson, Vancouver General Hospital, 1925), a son.

WELFORD—On April 22nd, 1929, at Chicago, Ill., to Dr. and Mrs. N. Turner Welford (Marion Hewitt, Winnipeg General Hospital, 1918), a daughter (Margaret Jane).

### MARRIAGES

AGNEW—CREELMAN—On May 3rd, 1929, at Vancouver, B.C., Pauline Creelman (Vancouver General Hospital, 1926), to Alexander Agnew, M.D., Vancouver, B.C.

BOYCE—OWEN—On April 10th, 1929, at Calgary, Alta., Olwen L. Owen (Calgary General Hospital, 1923), to Archibald H. Boyce, of Carstairs, Alta.

BRIDGEN—FALKINS—On April 26th, 1929, at Calgary, Alta., Hazel Falkins (Calgary General Hospital, 1924), to Walter Bridgen, of Edmonton, Alta.

BROWN—RILEY—On March 1st, 1929, at Edmonton, Alta., Esther Riley (Winnipeg General Hospital, 1927), to William Brown. At home, Provost, Alta.

CORBETT—EDMONSON—On April 19th, 1929, at Paris, Ont., Gladys Edmonson (Brantford General Hospital, 1924), to Dr. Corbett, of Port Dover, Ont.

HOPPER—McLAURIER—On March 22nd, 1929, Annie McLaurier (Winnipeg General Hospital, 1905), to W. H. Hopper. At home, Vancouver, B.C.

KENDRICK—NEWCORCOMBE—On April 17th, 1929, Irene Newcombe (Hospital for Sick Children, Toronto, 1928), to Dr. Thomas Douglas Kendrick.

MAXWELL—CAWLEY—On April 27th, 1929, at Vancouver, B.C., Doris Cawley (Vancouver General Hospital, 1925), to Allison Maxwell, Vancouver, B.C.

PEARCEY—STARK—Recently, Eleanor Stark (Toronto General Hospital, 1925) to W. Pearcey.

WILLIAMS—GRANT—On May 2nd, 1929, at New Westminster, B.C., Kathleen Grant (Vancouver General Hospital, 1927), to Murray Williams, Pembroke, Ont.

**DEATHS**

**BROBECK**—On April 13th, 1929, at Tacoma, Mrs. C. J. Brobeck (Lewella Stewart, Vancouver General Hospital, 1917).

**KELLY**—Recently, at Calgary, Alta., Agnes Kelly (Glasgow Royal Infirmary).

**MacMARTIN**—On April 8th, at Montreal, Lillian MacMartin (Montreal General Hospital, 1900).

**TITUS**—On April 12th, 1929, at Mayo, Yukon Territory, Mrs. L. H. Titus (Elizabeth McDougal, Medicine Hat General Hospital).

**WAINWRIGHT**—On May 3rd, 1929, at Montreal, Janet Wainwright (Montreal General Hospital, 1900).

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**THE CANADIAN NURSE**

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Editor and Business Manager: JEAN S. WILSON, Reg.N.

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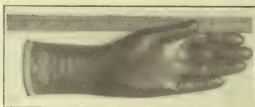
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# The Canadian Nurse

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JULY, 1929

THE COST OF SICKNESS - - - - -	<i>Dr. J. L. Bigger</i>	339
THE LAZARETTO AT TRACADIE, N.B. - - -	<i>A Sister of St. Martha</i>	348
SMALLPOX - - - - -		351
DEPARTMENT OF NURSING EDUCATION:		
METHODS IN TEACHING ETHICS - - - -	<i>- Charlotte Talley</i>	352
GRADUATION - - - - -	<i>Dr. Gordon Jackson</i>	356
DEPARTMENT OF PRIVATE DUTY NURSING:		
THE INTERPRETATION OF SOME CLINICAL LABORATORY STUDIES- - - - -	<i>Dr. A. G. McGhie</i>	357
DEPARTMENT OF PUBLIC HEALTH NURSING:		
MENTAL HEALTH IN INDUSTRY - - - -	<i>Muriel MacKay</i>	361
MENTAL HEALTH IN THE HOSPITAL - - -	<i>Gertrude P. Garvin</i>	362
MENTAL HEALTH IN THE HOME - - - -	<i>Isobel MacIntosh</i>	364
HOME NURSING TRAINING - - - - -	<i>Anne Anderson Perry</i>	366
CHANGES IN REPRESENTATIVES TO CONGRESS - - - - -		368
NEWS NOTES - - - - -		369
BOOK REVIEW - - - - -		376
OFFICIAL DIRECTORY - - - - -		379

## The Cost of Sickness

By Dr. J. L. BIGGAR, National Commissioner, Canadian Red Cross Society.

I find myself faced at the outset of my share in your programme with two difficulties. The first of these is, I am afraid, insurmountable. I cannot find a form of expression which adequately conveys my appreciation of the honour you have done me in inviting me to address you. I cannot imagine why I should have been chosen for this honour, why it should have fallen to my lot to form a link in the chain of notabilities to whom has been awarded the privilege and opportunity of speaking to the annual meeting of the Ontario Association of Registered Nurses. All that I can do is to tell you that I appreciate the privilege and the opportunity very sincerely, and to warn you in advance that the fact that I hold an executive office in a national organization is no assurance that I can speak to you either with authority or with facility.

The second of my difficulties is one which I did not foresee at the time when your invitation was extended to me. That was some time ago, and I was as brave and bold as the recruits were when they first dressed themselves in their uniforms, and the real war was many months and many thousands of miles away. In that exalted frame of mind I told your president that I thought you might be interested if I spoke to you about the cost of sickness. The subject interested me. Indeed, it is interesting a lot of people today, and none any more deeply than those of us, nurses, doctors and hospital authorities, who are brought daily and hourly into contact with it, from the receiving and not the spending end, fortunately for us.

I did not realize when the invitation was extended that there should be any serious difficulty in getting some facts together which might prove both

interesting and enlightening, and I felt that if I could present you with a resume of those facts you might not feel that your programme committee had been guilty of a serious error in judgment. Whether that committee was or was not guilty remains, I suppose, to be seen, but I would like to tell you at once that had I realized the extent of the task involved in the effort to get any facts and, even more, had I realized what a thorny path I had chosen for myself, how many pitfalls were concealed on the way, and how enormously tactful I should have to be—Agag walking at his most delicately—I think I would have selected some other subject, and this, in view of the recent controversy, would undoubtedly have been the wiser course.

All that I can say in my defence is that the storm had not broken—indeed there was not even a cloud on the horizon—when the subject was suggested and approved. And further, that just as I said a moment ago that my bravery when the invitation came was the bravery of the soldier who knew not war and was very far from the smell of powder, so tonight my bravery is like his when he was standing knee deep in a muddy trench with shells bursting on all sides of him, machine guns rat-tat-tatting in front of him, the zero hour at hand and the rum issue exhausted. Under those circumstances he was very careful not to take any unnecessary chances, and under these circumstances I am going to be as careful as he was, or even more so.

However, the cost of sickness is something in which all of us, professional and lay people alike, are profoundly interested. Whether we are brought into contact with it as patients or as those who are caring for patients, as payers or payees, there is not one of us who is not, or may not very readily be, deeply

(An address to the Annual Meeting of the Registered Nurses Association of Ontario.)

interested in the price we have to pay for illness and for the efforts made to cure or at least alleviate it. Nurses and doctors and hospitals get their incomes and revenues from it; their interest is obvious. The laity exhaust their savings and pile up loads of debts by it; the reason why they should be concerned in the matter is clear. Many complaints are made about it, but, as Mark Twain said about the weather, no one ever seems to do anything about it.

The subject is a very broad one. It has too many aspects to make anything in the nature of a comprehensive discussion of it at all possible. It touches our present social organization at dozens of points and our attitude towards it is conditioned and influenced by practice and tradition and custom to the degree that it is very difficult, if not impossible, for us to think of sickness and the methods we employ in dealing with it in any other way than the way we have been brought up.

### THREE QUESTIONS

But, nevertheless, there are three questions one might ask as a form of approach to the subject. There is the question of how much the people of this country are now paying for the illnesses from which they suffer. There is the question of what they can afford to pay. And there is the question of whether the cost might not be more evenly distributed and the service, both professional and hospital, more adequately remunerated.

The advantage of this form of approach is that no definite or exact answers can be made to any of these questions. Estimates can be formed, but these are hardly more than guesses. However, they do, I think, throw some light on the situation and provide one with food for thought. And perhaps an attempt to answer them may help to visualize the whole problem which is exciting a very great deal of attention. In our professional publications, in both the serious and the lighter magazines, in the press and in other publications of all kinds, there are constant re-

currences to the question of what the highly scientific, highly organized and highly expensive present-day professional service is worth, what its actual value is to the ordinary people who constitute the bulk—the vastly preponderating majority—of our own people, and of all other nations.

Before setting out to try to answer our three questions, one might make an attempt to assess the value of the service, and in trying to do this, let us take two types of cases. Let us take the young father with a severe attack of gangrenous appendicitis, seized with excruciating pain, taken from the office in which he is employed or the trade at which he works, admitted without delay into a modern hospital, operated upon within an hour or so, out of danger two or three days later, and back at work within three weeks. His case seems to be a complete vindication of the value of our present arrangements. Without them invaluable precious time must have been wasted, the necessary operation would have been performed under great difficulties, post-operative care would have been based rather on kindness than skill; and the chances for saving his life and restoring him to productive occupation must have been enormously lessened. Modern medicine as practised by doctors, nurses and hospitals has revolutionized the situation as far as this type of patient is concerned.

But there is another side to the picture. There is the case of the terminal and inoperable cancer. Let us suppose that the patient is the wife of a hard-working, honest, useful, independent citizen who, during the fifty years of his life, has provided food, shelter, education and recreation for his family, but in doing so has been unable to lay up anything very much for the inevitable rainy day. His living and that of his dependents has come from his earnings and these have never greatly exceeded the calls made upon him. Now this man has the characteristics which are common to us all. He desires every possible



comfort and every possible relief for his wife. The doctor must make fairly frequent visits, nursing is needed by day and by night, drugs and so on must be continually supplied. At the end, after months of hopeless attention, the patient is mercifully released by death and only the bills remain to tell the tale. How can he meet them? His savings have long ago disappeared. His income throughout the illness has been entirely insufficient to keep him abreast of the accumulating costs. His future is mortgaged to the hilt. Modern medical science, the practice of the art of healing as we have it today, has imposed a burden upon him far and away beyond his capacity, though he has embarked on no expense which modern medical practice does not consider to be unavoidable in the circumstances.

For there is always one thing one must remember. It is that we are, all of us, consciously or unconsciously, willing or unwilling, more or less completely governed by the public opinion and the common habit of our day. If the doctor and the relations and the friends and the neighbours all think that a certain course is the course to be followed, we follow it. In circumstances such as these it is not good form to speak of money. It is inhuman to consider money in comparison with human suffering and human life, and consequently, when our time of trouble comes upon us the whole environment in which we live bears down upon us with the perhaps unrealized but nevertheless irresistible pressure of its opinion and customs, and we do as the world does quite irrespective of the costs of our action and without anything like the consideration that we would invariably give to any other transaction.

In this example we have quite a different picture from that which we had in the other. We have a chronic long drawn-out and hopeless case where our only task is to provide as much comfort and alleviation as possible until the patient is finally relieved by death, and we use in pro-

viding it the same highly expensive machinery that we used in the first case because we have no other. Would it be improper to suggest that just as one uses one kind of equipment for one task and another for a different one—say a light high powered car for fast travel on a highway and a broad wheeled tractor for heavy loads on soft ground—so we might by taking thought adapt our equipment to the different demands which are made upon it in this very diversified business of caring for those who are sick. Speaking very broadly we have today only one form of machinery, by which I mean our organization comprising nurses, doctors and hospitals, and this form does not allow of much elasticity in its application but is, rather, an all-or-nothing proposition, to make use of which inevitably involves large expenditures.

What is the sum of these expenditures? How much are we paying? No exact answer can be given. Only an estimate of them can be formed, and that without a full knowledge of the facts. But a moderate estimate, which might best be called a fairly reasonable guess, is that in Canada we pay, individually and directly, somewhere about \$150,000,000 per annum for the privilege of being looked after when we are sick. This is the amount of money you and I and all the rest of our fellow countrymen and women pay out of our own pockets to our doctor, our nurses, our hospitals and our druggists. It takes no account of any money that may be wasted on quacks. It does not include the amount we pay to our dentists, nor the couple of hundred thousand dollars a year which dispensaries cost us. It does not give the least consideration to the money we lose to ourselves individually and to the community collectively by being sick. But perhaps in a discussion of this kind these items may quite fairly be left out and only the four major items of doctors, nurse, hospital and drugs need be taken into account.

If you divide the bill by the number of those who are available to pay it, you find that to make up the total every man, woman and child in the Dominion should contribute almost \$16.00 a year. The matter is not, however, as straightforward as that. One must remember first of all the class of people who are unable to pay anything whatsoever, the submerged tenth as they are called. These reduce the number of those upon whose shoulders it falls to pay this annual bill of 150 millions, their share being added to that of those who can pay. And to render the question still more difficult is the problem of the people in newly organized districts of whom we have so many and those in the places where only the barest living can be secured, with whom actual cash is a much less common commodity than it is with those whose work is invariably paid for in the coin of the realm. Speaking broadly, one might say that two-thirds or even more of the bill is paid by dwellers in cities, towns, villages and the more prosperous rural districts, and that these constitute not much more than half of our whole people.

Taking these facts into consideration I do not think that we would be far out if we said that the 150 millions we have to find each year to pay for our sickness is paid by no more than five million people and if these five million represent fathers, mothers and the average of three children to a family, it means that one million bread-winners have to pay an average of \$150.00 a piece a year for the nursing care, the hospital service and the doctors' fees which they require on account of the illnesses from which they suffer during that period of time.

The question of whether we can afford to make these payments comes next. The answer is, we can, and the proof is that we do. We are today supporting our doctors, our nurses and our hospitals and we are paying for our drugs and supplies, so that it is obvious that we can afford the cost. But it is eminently possible that while we can afford this cost we

ought, for our own sakes, to be affording more. Or, to put it another way, it is possible that we are not getting all the nursing, medical and hospital service we need for our welfare. We may be getting all we can afford to pay for but we can only afford to pay for so much, and so much is not really all that we need. No one has any doubt that people are putting off consulting doctors, postponing engaging nurses and doing without hospital care because they cannot afford to have these things though they know they need them. Or, in still other words, the present costs of these services are such that the benefits they provide have sometimes to be forgone, and if they were used as fully as they are needed, the same rates being charged, we would find that our total figure would have to be increased very materially.

But there is another and much more important angle to this part of the problem. Which of us is in fact paying the bills? Did you pay your share last year? Did I? Did our friends and relations? No, not unless they and we had the misfortune to be among those who needed the services. If we were lucky, if we escaped the necessity of calling in a doctor or engaging a nurse or occupying a bed in a hospital, if we visited a drug store only for tooth paste, kodak films and chocolate sundaes, we did not pay our share of the bill. Those who paid were those who had not our good luck. They did not escape, as we did, illness or accident. They had a share in the slings and arrows of outrageous fortune in the way of influenza, or pneumonia, or appendicitis, or a broken limb, or a new baby or some other of the many mischances to which we are all exposed and because of which the hospitals and the druggists and the doctors and the nurses manage to carve a living for themselves out of this hard cruel world.

As individuals we might have been able, though indescribably reluctant, to pay our share of the bill but we didn't have to. The whole cost fell

on those who, by their misfortunes, were in the least satisfactory position to bear it, and their load was enormously greater because they were in fact only a fraction of the whole number of those who might have divided the expense between them. No one knows how many people in Canada consult a doctor, employ a nurse, enter a hospital or need medicine in a year, and some of these things can never be ascertained. If they were known, however, I am confident that we should be startled and horrified. We should immediately be faced with the question that if this is the state of affairs in a supposedly civilized country either there is something radically wrong with our form of civilization or else the condition of the uncivilized must be indescribably bad. But that is another story.

Certain figures, however, are available. We know, for instance, that in 1927, approximately 185,000 people were patients in Ontario hospitals of all kinds, and from this we might be justified in deducing that some half a million of our fellow citizens throughout the Dominion were hospitalized in that year. Let us assume that three times this number were treated at home and we have two million sick people in the year 1927 upon whom fell the burden of paying the bill of 150 million dollars. But taking the average grouping which obtains in Canada today we find that each person belongs to a family of approximately five, and bearing this in mind, we find that, on the average, the whole bill was charged to the breadwinner or breadwinners of such families, or in other words, that 400,000 families paid the bill at an average cost of \$375.00 a family. Now when you realize that the average income of Canadians is under \$1,800.00 a year, you understand that out of our approximately two million families one-fifth pay, on the average, about 20 per cent of their total earnings each year because of sickness.

Now had these 400,000 families, comprising two million people, shared the cost among them the burden to

each might not have been so intolerable but we don't do business that way. The longer we are disabled, and consequently the less able we are to pay, the greater is our share of the cost, which hardly seems to be a very sensible arrangement.

Looking at it in this way it appears to be both an unjust and a stupid arrangement, but there it is and so will it remain unless and until we are prepared to change it. To do so would mean that we must change our attitude of mind about the whole business of providing treatment for sickness, but we are changing our minds and changing them so profoundly about so many things that I imagine there should be no insuperable difficulty about our changing them in this respect also. And I should like to suggest, speaking professionally and in parentheses, that if we do not change them and lead and direct the general change of mind, a change may be forced upon us by the irresistible weight of public opinion and perhaps such a change may not be as welcome to us as the change for which we ourselves proposed and strove.

In order to see whether any further light may be shed upon the question, let us consider for a moment the history of hospitals and of nurses and of doctors. Let us see if some of our present difficulties do not arise from our ideas about these factors in the problem and whether these ideas are not based upon their historical backgrounds which are not warranted by the facts of today. In other words, let us see if we are not thinking about these three enormously important factors in our lives rather in terms of what they were than in terms of what they are.

The doctor derives from the priest and the magician and if he has lost his priestly character he still retains something of the other ancestor and, in the popular mind, is held to be something of the wizard. Indeed, people still want wizardry from doctors; they do not want pure science. They want the magic touch rather than the skilled brain. For this

reason, among others, doctors are extreme individualists. Our relationship with our patients and with the world is an individualistic relation, and we find it enormously more difficult than lawyers or architects or accountants or chemists or any other scientists to work in collaboration. We like best to stand on our own feet and deal with our patients as far as possible off our own bats. We may have to change all that. Indeed some signs of such a change are today apparent but, nevertheless, today we walk alone rather than in company.

The origins of the profession to which you belong, while perhaps lacking a little of the mystery of those of the medical profession, are still to be seen in the attitude of the public towards you and perhaps also in your idea of yourselves. You have a noble tradition—the tradition of devoted singlehearted women who throughout the ages have striven without hope of earthly reward to alleviate misery and mitigate suffering. You derive from sisters-of-mercy, from convents, from sisterhoods and from all those institutions to which sick and suffering people might look for succor. Only, as it were, yesterday did you become separated from the purely charitable and altruistic organizations in which you had your beginnings and the mark of these organizations is still upon you.

#### HOSPITALS

Looking at the hospitals we find much the same kind of story, with this additional factor, that until quite recently, as time goes, they were called upon to accept and care for only those who were entirely unable to provide care for themselves. They gave to the friendless and the outcast what he could find nowhere else. Until quite recently the independent citizen did not take the hospital into consideration nor avail himself of its service when he required attention. So long as he could pay he looked elsewhere for such care as he might

require. The change from this situation has been too sudden for us to have wholly adjusted ourselves to it as yet. The hospital today is caring for an infinitely larger number of independent and respectable people than of the friendless and the dependent, but its wards still retain something of the old stigma and so long as the independent pay-patient fears that he may be classed as one of the failures, for so long he will be inclined to deprive himself of advantages that the hospital might secure for him. Might there not be some readjustment of our attitude to this part of the problem?

There is also another feature of the same thing, a material feature, composed of bricks and mortar. Has it, do you know, ever been considered whether it would not be possible, without any serious additional cost, to secure something of the privacy which everyone would like to have when they are sick? Our hospitals seem to me to have followed an old idea of accommodation for patients though the character of the patients has been very largely changed with the changing times. I ask the question because of a recent occurrence in which I was personally interested. A young man of my acquaintance got a job which paid him \$175.00 a month, and promptly got married. In the course of events a baby was expected and arrangements had to be made. With some searching he discovered a hospital, agreeable to the doctor who of course insisted on hospitalization, where he could obtain a private room for the expectant mother at a cost within the extreme limit of his means. The baby was duly born and when all the bills were added together it was found that the child had cost altogether \$275.00, which I understand is a very moderate price to pay for a baby these days. Peculiarly enough both the parents considered him well worth the price, though they realize they won't have him paid for till after his second birthday, and that before he can have a little sister the family income must be greater than it is.



It occurred to me that while the mother was entirely justified in thinking that a private room was essential, it must have involved additional nursing costs and that these might have been lessened had the building been so constructed that all the necessary privacy might have been secured without solid walls and closed doors so that the task of the nurses might have been simplified and thereby rendered less expensive.

#### SOLUTION

And so we come to the last question; the question about the possibility of a more equitable division of the price which we are paying. This is not a question of the value of the services. From the point of view of the patient, whatever the cost, it is worth it, for you cannot estimate the monetary value of life or the restoration of health. There is absolutely no way by which these can be reduced to a dollars and cents basis. No sum of money is too great if the desired results have been obtained. But there is another aspect of the matter and it is this aspect that is now beginning to stimulate general curiosity and to raise a doubt in the public mind. It is the aspect which may perhaps be best expressed as a question along these lines. Are our sick people as a whole getting a square deal? Are they called upon to pay too dearly for their misfortune in being sick? Is there any equitable way of arranging matters so that, while those concerned in the business of caring for them are properly and sufficiently remunerated for their work, the burden of cost may be more evenly distributed? Is this whole business of caring for the sick in a state of confusion between providing the necessary care for those who can afford to pay nothing on the one hand and charging all that the traffic will bear on the other?

Take the hospital to begin with. It is a matter of common knowledge that, generally speaking, the private ward patient pays more than the cost of the service given him so as to lessen the loss on the non-pay-patients.

In other words, if you or I have the bad luck to fall sick and to require hospital treatment, we being what we are and feeling as we do that we have no choice in the matter but to conform to the usual practice, and keep up with the Joneses, pay not only the cost of our own sickness but also for a part of the sicknesses of others. This is certainly not equitable and might be remedied without delay. And we might also look at it another way. I stay at hotels a great deal. I get a comfortable, quite expensively furnished room and a private bath. The linen is continuously immaculate, and the service excellent. I get three excellent meals, beautifully cooked and expeditiously served. In addition I may freely use the public rooms of the hotel, luxuriously furnished drawing rooms, writing rooms and lounge rooms. I am provided with music at my meals. I may have a radio set at my bed-head and I have the use of a private telephone. For eight to ten dollars a day I live luxuriously and, provided there are enough of me in the hotel, the management makes money.

Now in a hospital, which after all is a specialized hotel, I get a much smaller and less expensively furnished room; I may or may not have a private bath room; my meals are infinitely less expensive; I have no public rooms in which to disport myself—if I enjoy a session in the operating room I pay extra for it—I wholly lack a musical accompaniment while eating and the actual domestic service is on a smaller scale. Altogether the fixed charges for comparable items must be very materially less in the hospital than in the hotel. I should imagine that so far as these items are concerned, the cost should not exceed \$3.50 or \$4.00. The difference between the actual cost and the charges made is presumably for nursing service but if I require much nursing attention I must engage my own nurses and pay for them and for their meals also. It seems quite obvious that I get better value for my money in the hotel, and I confess that were the

choice given me I should prefer three weeks in a good hotel to three weeks in hospital.

#### DOCTORS AND NURSES

Finally, let us consider the difficulties of the two professional groups, the groups which you and I have the honour to represent. The first thought that occurs to me is that we are the battleground of two incompatible ideals. The first is the ideal of providing our patients with the very best service, the most complete and single-hearted attention of which we are capable, quite irrespective of the cost to ourselves in labor and energy and devotion. This is the ideal of both nursing and medicine, our inheritance of the noblest of traditions through many centuries. The other is the result of the gradual encroachment of a materialism upon occupations which had their origin in idealism. This encroachment has not been our fault. The world has become almost wholly materialistic. Its standards are almost invariably commercial. It thinks almost entirely in terms of the almighty dollar.

These two attitudes—our inherited idealism and our modern materialism—divide our councils and confuse our thinking. Altruism and commercialism, unselfish service and money-making cannot work smoothly in double-harness. They are not a well-balanced team.

And there is a second misleading factor. It is the popular belief that as a class all professional people are well paid. In spite of their experience, professional people themselves subscribe to this notion, and if they are themselves ill-paid they feel that there is something wrong. The idea is, however, utterly erroneous; nothing is further from the truth. In proportion to the necessary period of preparation for a profession, to the intelligence and the energy which are essential to its practice, the returns are much smaller than in many other occupations. It is notorious that the incomes of ministers and teachers and doctors and nurses and even lawyers

are very small in comparison with people of similar capacity in the commercial world. Theirs are not, on the average or indeed except in occasional instances, the pursuits which are well rewarded financially. Very few of us, unless we are lucky speculators, are able to retire with a competence or a pension while life is still enjoyable. We only stop striving to make a living when we find that we are no longer able to earn one. The truth is that if we undertook our present jobs with the idea of enjoying good incomes, we are stupid or misinformed about the facts. They are not money-making activities for most of us. Indeed, considering the standard of living which these occupations enjoin upon us, many of us are lucky to make ends meet.

#### IDEALISM, MATERIALISM

So that, in the last analysis, we are faced with an extraordinarily difficult problem. Are we to be idealists or materialists? Are we to commercialize our professions, or are we to remember their derivations and traditions and give ourselves to them with single-hearted devotion, realizing that our reward is the sense of duty done and the affection of those whom we have been able to serve? As things are today that is our problem and each of us must arrive at some solution of it for her or himself.

But I believe that there is a way out of this difficulty. I believe that we can, if we want to, reconcile these apparently incompatible ideals. I believe we can find a solution of the matter, if we strive earnestly enough, and that we will find it in the application of the new principle which is taking, more and more, the place it deserves in all the activities of humankind today. I refer to co-operation. We have co-operation in business. We have secured co-operation in many of our public services. We are getting co-operation even in international relations. Today co-operation is the governing idea in most of our affairs and I ask you if we cannot apply it to our own problems.

Let us envision a community in the year of grace 1960, imaginary if you like but quite within the bounds of possibility. Its citizens have agreed that the health of the community, which is after all only the sum of the health of all the individual people of which it is composed, is the absolutely primary requirement and must be their first consideration if they are to enjoy life, and they have arranged that the burden of caring for the sick amongst them should be a common duty, shared by all, just as education of the young is with us, and with this end in view they collect the money needed for this purpose through the usual system of taxation. No one is compelled to use the service so provided, just as today no one is compelled to send his children to the schools that are provided but may send them to private schools if he likes. In this community the standards of the medical and nursing and hospital services are maintained at the very highest level and are completely dependable. No one has the savings of years exhausted in a few months or a load of debt imposed upon him by his personal misfortune in the way of sickness, and all concerned, the public, the professional people, and the whole community enjoy benefits almost unobtainable today except by those who must pay heavily or those who pay nothing.

The complete requirements of this community, all that it could possibly need in the way of doctors and nurses and hospitals and drugs could be met by an expenditure of \$20.00 a year a piece, or very little more than the present per capita cost of the education of the children in Ontario. This money would provide them with the most expert physicians and surgeons, with the most skilled nurses, with efficient and sufficient hospital care and with all the medicines and so on they could use even at our present incidence of sickness.

But in a community such as this, a community intelligent and clear-sighted enough to realize that an injury to any one of its members is

an injury to all and that very great advantages can be secured by simple measures of co-operation, the incidence of sickness would be much less than it is with us today. The entire prevention of all preventable disease would be its watch-word and its goal. Its citizens would completely realize the absolute truth of the old aphorisms—so old as to be platitudinous—about the stitch in time, the stable door and the stolen horse, the fact that prevention is cheaper than cure. And more and more would their "sickness" fund come to be spent on preventing sickness rather than on curing it, so that in time their need of doctors and nurses and hospitals would be lessened, their burdens would be lightened and their happiness enormously increased. But do not fear that concurrence in the suggestion I have had the temerity to make to you will reduce the chances of our own employment. The fruits of the scheme are at best as yet no more than in the bud and the day of their ripening in a world where sickness and sorrow are to be diminished so far as human knowledge and intelligence can diminish them is still far off in the dim and distant future.

To undertake to put into operation a plan of truly co-operative nursing and medical and hospital service would mean a very substantial alteration of our present arrangements and a profound readjustment of our present views, but man is an adaptable animal. Indeed he has survived only because of his adaptability: without it he would long ago have perished from the earth. And in view of this adaptability, does the idea seem fantastic? Is it impossible to imagine a group of doctors working hand in hand to care for all the sick of a community? Is a co-ordinated nursing service visionary? I do not think so. I believe that the details of such a scheme could be worked out without any serious difficulty. I believe that our professions are basically imbued with the spirit of service, and that it is at all times existent among them. We remember how this

spirit was displayed in the war, and we know that the opportunity is all that is needed for its display in peace. I believe that idealism rather than commercialism governs our professions and that only a suitable opportunity is required to make the fact abundantly evident to those who are questioning our motives or the attitudes we are accused of taking.

I believe a degree of harmonious relationship between the public and our professions could be realized to an extent which is at the moment hardly

realizable. I believe that of all the advances which humanity has made since the days of the cave and the wattle-hut there has been none so striking and none so full of promise for the future as our increasing ability to work together, effectively and harmoniously, and that just as by co-operation, by working together honestly, faithfully and unselfishly, we can gain our objective in this question of the costs of sickness, and how they may be more equitably divided between us.

### *The Lazaretto at Tracadie, N.B.*

By A SISTER OF ST. MARTHA

The Sisters of the Hôtel Dieu of St. Joseph play a very important rôle in the early history of Canada. Whilst their great pioneer work for this country excels that of many statesmen and politicians whose names appear in large letters on many pages of history, these devoted women continue their splendid work of helpfulness throughout this vast North American Continent. To speak of the Hôtel Dieu of St. Joseph is to evoke a past replete with hallowed memories, humble yet glorious, a past that is little noted by the world but written in golden letters by the recording angel.

It is in the great wide field of hospital work that the Hôtel Dieu nuns have distinguished themselves. When the wave of standardization sponsored by the American College of Surgeons swept over the continent, their hospitals were amongst the first in Eastern Canada to measure up to standard requirements. However, their self-sacrificing devotedness to duty is perhaps better shown in their work for lepers in Tracadie, N.B.

A variety of opinions exist as to how leprosy made its first appearance in New Brunswick, but the most commonly accepted theory is that sailors who were aboard a French vessel from Morlaix, which was shipwrecked at the mouth of the Mirimichi River early in

the winter of 1758 spread the disease. This supposition is verified by the fact that this same boat—the “Indienne”—had been carrying on trade with Levant, where from the earliest ages of civilization the inhabitants had been infected with leprosy. The sailors aboard the “Indienne” were kindly cared for by the good people along the shores of the Mirimichi, and thus the disease was spread.

It was not till the year 1844 that the Provincial Government became awakened to the fact that some of the people were infected with leprosy, especially in the counties of Gloucester and Northumberland. A medical commission was appointed to make inquiry into the character of this loathsome disease and report on the means of lessening its ravages. Upon the repeated demands made by Father Lafrance, a devoted priest who was much interested, a pest house was built on the Sheldrake Island in Mirimichi Bay, eight miles from Chatham. This helped to check the progress of the disease, but it was far from providing comfort for the poor sufferers. Whilst due credit is given to the Provincial Government of the time for its generosity towards the lepers, yet it is regrettable that the body of men which it invested with its authority to manage the affairs of this leper



*colony* were lacking in a true sense of their obligations, and the poor sufferers were doomed to great misery. However, no institution is perfect in the beginning, and the rude wooden structure of 1844 paved the way to better things.

In the meantime, the lepers who were thus segregated in this pest house remained helpless and hopeless, and their sad story can never be adequately told. Their paid attendants, who even at that time had the instincts of our modern "safety first," rendered only such service as could be ministered without danger to themselves. Doctors seldom visited the place, and the laws of cleanliness and sanitation were sadly ignored. Thus, these poor unfortunates rotted away, with few to pity them, except the kindly priest, their sole visitor, whose tender heart went out to this afflicted portion of his flock. Through his efforts, a new building was erected in Tracadie, N.B., a short distance from his church and parochial residence. It was a low, rudely-constructed building and surrounded by a high, iron-spiked fence, which shut off the view of land and water. The lepers were transferred here on July 25, 1849. With all its prison-like gloominess, this afforded them better living conditions than they had yet known. The Board of Health appointed Dr. Labilloy, a young and clever physician, who had made a particular study of leprosy, in charge of the patients. For three years he devoted himself indefatigably to their care, and there are documents extant today to show that he wrought immense good in the hospital.

The fall of 1852 was marked by two misfortunes for the lepers. Dr. Labilloy, whose eminent service meant so much to them, left for Dalhousie, and his departure was sincerely mourned with good reason. Soon afterwards (on September 9, 1852), the hospital was reduced to ashes, and it was too late in the fall to think of reconstruction. A tempo-

rary building afforded shelter during the winter months, but it was far from comfortable. Dr. Nicholson succeeded Dr. Labilloy, and his untiring devotion and skilled care brought a ray of comfort to this desolate home of suffering. In 1865 he was replaced by Dr. A. C. Smith, who capably filled this office till his death in 1909.

In 1860, the Right Reverend James Rogers, Bishop of Chatham, visited the Lazaretto for the first time, and his kind heart went out to the sufferers. This visit proved to be the dawn of a new day in the history of the province, for the zealous bishop decided there and then to confine the care of the lepers to the Religious Hospitallers of St. Joseph.

In was on September 9, 1868, that the Sisters arrived in Tracadie and were received with manifestations of joy, which found full expression only when the warm-hearted inhabitants assembled in the church to sing the *Te Deum*. On the following day this little band of zealous pioneers set resolutely to work in a united effort to better conditions at the Lazaretto. There was ample room for improvement for one cannot imagine today much less write the revolting state of this filthy abode of misery and death, but these noble women set themselves energetically to tasks that were indeed revolting to poor human nature.

Of this event a writer in a local paper pathetically remarks: "The night had been dark and full of horrors for the poor exiles of Sheldrake. Dawn had risen slowly but full of hope on the horizon at Tracadie. At last full daylight broke forth and ushered a day chronicled in letters of gold in the annals of the *Hôtel Dieu*. A ray of indescribable gladness penetrated the souls of the poor lepers, so long had they been deprived of the care and pity their lamentable condition required."

Here, as elsewhere, the Sisters of the *Hôtel Dieu* proved themselves the true spiritual daughters of Jean Mance. Fearless and dauntless they

took charge of these poor desolate creatures and brought order and cleanliness into this abode of terror and sorrow. They washed the bandages, dressed carefully the dropping limbs without the faintest sign of repugnance or disgust, for they remembered the words of the Master: "As you did it unto the least of these, you did it unto Me." Soon the rooms within the grim and forbidding walls of the Lazaretto took on a new aspect, but to do this was no light task and it required superhuman strength and courage to accomplish it. The secret of it all has been chanted truly and feelingly by the poet who said: "The vase was human, but the flower divine." Unquestionably, souls less courageous and fearless, less enriched with sublime faith and heroic charity, would have wavered more than once in sight of the squalid and ill-kept apartments, where dwelt the victims of the loathsome and gruesome disease.

How the heart of the poor leper, hitherto helpless and hopeless, forcibly separated from parents, wife and children, torn with anguish and sorrow, must have been comforted at sight of these devoted women who so kindly and sympathetically ministered to his wants! Perhaps the greatest miracle of all is that amidst poverty and want, without accessories or conveniences, with the miserable surroundings and unsanitary conditions under which they labored, not one Sister ever contracted the disease.

However, it was not the healing of their patients' bodily ailments nor the revolutionizing of domestic conditions that claimed their foremost efforts. Their first aim was to win their poor souls to God. Their first step in the fulfilment of this delicate mission was to read good books and pleasing anecdotes for the unfortunate victims, and to teach them how to bear their terrible sufferings with peace and resignation.

The first year which the Hôtel Dieu Sisters spent in Tracadie was marked

by hard work, discomforts and rigorous poverty. The Government did not offer any assistance during this first year, but in response to the call of their pastors, the generous Acadian farmers gave splendid assistance with large supplies of produce and by their labour.

At the end of the first year, the Sisters' work was happily recognized, and the Provincial Government gave some assistance. In 1880, through the persevering efforts of Dr. Tache, who was at that time professor at Laval University and Deputy Minister of Agriculture, the Federal Government took the institution under its care, and from that day it has provided the very best of everything for the poor lepers. Henceforth the Sisters became sole administrators of the hospital, and no one ever had reason to regret the fact. In 1894 the Federal Government decided to erect a new building which would afford comfortable quarters for the inmates. This structure of stone was built at a little distance from the old one and the patients were removed here in the spring of 1896. Unquestionably this building does credit to the Government that constructed it. The site is an ideal one, commanding a magnificent view of Tracadie Bay, separated from the Gulf of St. Lawrence by a narrow beach, which is fringed by the white lacy foams of the sea, into which two rivers wind their way, and between their mouths run the stretch of land whereon stands the Lazaretto.

The interior of the hospital is well arranged and the wards are spacious, well lighted and splendidly ventilated. The lepers find here order, comfort, cleanliness, good food and recreation. They are allowed to stroll through the lovely fields around the hospital and enjoy such amusements as can be safely provided. Those who are able may be seen fishing and hunting on the shores of the bay, and strains of music may be heard within the walls, as well as in the adjoining gardens, where they may be often

found on a summer's evening, singing their national or patriotic songs. The comforts of religion are theirs to the full, and their thoughts are directed to the great end which is drawing near for most of them.

Owing to the splendid sanitary conditions, and the cleanliness with which they are surrounded, the nutritious

food provided for the patients and the excellent care they receive, the disease is diminishing rapidly and the remaining few pass their days comparatively happy, preparing devoutly and hopefully for the END. Perhaps the majority of happy-go-lucky worldlings might well envy the lot of the lepers at Tracadie, New Brunswick.

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### *Smallpox*

During post-graduate week at the College of Nursing, London, Major Parkinson, R.A.M.C., late M.O.H., Gibraltar, in speaking on "Smallpox: Methods of Prevention and International Control," is reported by The Nursing Mirror, April 20th, 1929, as expressing the opinion that in a country where vaccination is not compulsory one may, sooner or later, expect a serious epidemic of smallpox. The speaker emphasized the necessity for the isolation of smallpox cases, showing that a mild case requires the same isolation as a more virulent one. He explained that:

"In Germany vaccination is compulsory at birth and again at twelve years of age: in France at birth and again at twelve and twenty-one: in Gibraltar at birth and again at twelve years. Germany possesses no isolation hospital for smallpox, because the disease is non-existent. Many countries which surround it, especially Russia, suffer from the disease, but Germany remains immune. Gibraltar is in daily communication with Africa, Spain, and other countries where the disease is usually more or less prevalent, and it is also a port. But it has no small-

pox because vaccination is compulsory. Where only thirty or forty per cent. of a nation is vaccinated, it follows that quarantine and isolation must exist."

In referring to international control, Major Parkinson said that such control of smallpox is not easy. "There are regulations with regard to plague, yellow fever and cholera, including the quarantining of ships, and the League of Nations issues weekly bulletins which are passed on by the health authorities to one another, so that the officials at the principal ports have authentic information as to whether the place whence the ships come are infected or not. There is no such regulation with regard to smallpox. Only an entirely unwritten understanding exists between the nations whereby it is notified. Contacts are usually detained for a few days; their names and addresses taken, and particulars forwarded to the medical officer of health in the district in which they are going to stay. Through these bulletins a port is not given a clean bill of health until the authorities are convinced that it is free from infection."

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## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

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### *Methods in Teaching Ethics*

By CHARLOTTE TALLEY

In teaching ethics to student nurses the subject should be presented in such a manner as to arouse sufficient interest to lead to the upbuilding of the students' ideals of thought and conduct.

A broad viewpoint of the subject of moral science is important as a foundation to build concepts of ethical conduct that will be the result of the students' own thinking and not merely opinions imposed on them by the instructor.

So we see that there are several important points to be considered. We must enlist the students' interest, we should give them as broad a viewpoint as possible, and also we should impart information that is workable to aid in character development.

Most people are keenly interested in ethical questions without, perhaps, being fully aware of the fact. It is the person in the public eye who measures up ethically who wins popular acclaim. Every book of fiction we read, every stage play or motion or talking picture we see, holds our interest through characterization or the ethical or unethical conduct of the persons depicted therein. A faulty character may have appeal, but generally because of possessing some redeeming trait or traits. Mere beauty may attract because it is or seems to be the "outward and visible sign of an inward or spiritual grace," but alone it will not suffice to hold us.

In real life we care for very faulty people, but they also usually possess some ethical quality which endears them. We may not analyze their characters to discover that it is their cheerfulness, good-humour, generosity, sincerity, loyalty, sense of justice or loving-kindness which makes us like them, but this is true.

The daily events in our lives are constantly affected by the ethical or unethical conduct of others. Our own conduct has its effect upon others often more than we realize. The field of our daily work is the laboratory wherein we may experiment as to how we may improve our characters. It is not difficult to interest students in the subject of ethics if we show them at once the way the entire subject is directly concerned with our daily living.

The best way to do this appears to be to begin at once with ethical discussions. Preliminary students are apt to be absorbed in their new environment. Concentration on the qualities for which they are marked in their efficiency reports is sure to have an appeal. Problems submitted by students which relate to their work or their new social relationships have important significance and soon reveal the necessity in nursing for making independent ethical decisions.

We want to assist students to decide ethical questions wisely, not by giving them set rules to follow, but by showing them how to apply the ethical principle which is involved in the problem to be solved.

The rules of professional etiquette as required in the individual school are usually given to preliminary students at the beginning of the course in ethics.

Since moral science is both historical and experimental, we can present the broad aspect of the subject by carrying the history of the development of ethical thought and conduct and the consideration of ethical principles concurrently with the exercises to develop character qualities and the discussion of ethical problems.



This may be done by devoting half of the lesson periods to each purpose or by alternating the periods and devoting one to historical and the following to experimental ethics.

The latter method makes for better concentration on the lesson assignments, but the first few lessons are more satisfactory if the former method is employed, so that students will realize better the objects of the course.

We check up on results at the end of the course in accordance with what has been the general or educational aim, and it is well to advise students what this is. For instance, it may be: 1. To impart knowledge of general and

nursing ethics to assist students in deciding ethical questions; 2. To be an aid to students in improving their efficiency reports and in character development.

An outline of the history of ethical thought as it has developed through the centuries, correlated with historical epochs and nursing events, is an aid in clarifying the subject of ethics as treated historically, and it is a good plan to have this on the blackboard to be copied into note-books. This need not be memorised to be helpful.

Such an outline formulated by the writer is as follows:

#### OUTLINE BY CENTURIES OF THE HISTORY OF ETHICAL THOUGHT CORRELATED WITH HISTORICAL EPOCHS AND NURSING EVENTS

##### B.C.

Ethical principles necessary to the maintenance of group life: good of the majority.  
The rights of others.

Confucius  
(551-478 B.C.)

Golden Rule (negatively stated.)

Buddhism  
(568-448 B.C.)

Laws of Sanitation.

Hebrew Literature.

Golden Rule.  
Ten Commandments.

Greek Literature.  
Epictetus.

Golden Rule.

Socrates  
(469-399 B.C.)

Socratic method of arriving at truth by question and discussion.

Greek ideal of perfection of the individual sometimes led to the neglect of the chronically and hopelessly ill.

Know thyself.

Epicureans.

Pleasure the only good.

Zeno.

Stoic's law of self-control.

Plato.

Platonism—Rule of subordination.

Aristotle.

Aristotelian sense of proportion.

##### FIRST CENTURY A.D.

Art of nursing developed by Marcella, Fabiola, Paula and Phoebe.

Christianity.

Golden Rule, Love and Non-resistance, Humility, Pity, Service, Hope and Faith, Self-Sacrifice.

## MIDDLE AGES (476-1500 A.D.)

Chivalric, monastic, and military ideals incorporated into hospital management.	Religion and Militarism.		
	Group, clan and class ideals.	Abelard 1079-1142).	Treated ethics as a separate study. Held the individual conscience as criterion of moral judgment.
	Crusades.		
	Discovery of America, 1492.		
	3rd Century.	Neoplatonism.	Commerging Christian and Jewish ideas with Greek philosophy and Oriental mysticism.
	14th Century. Renaissance.		

## MODERN ERA

Decline of religious orders and in hospital care of the sick.	16th Century. Elizabethan period.		
	Reformation.	Francis Bacon (1561-1626)	
Organized charity under St. Vincent de Paul. Advance in nursing through Sisters of Charity.		Thomas Hobbes (1588-1679)	
	17th Century.	Locke.	
		Spinoza.	Two-fold value of knowledge.
	18th Century. Age of Reason.	James Mill.	Psychology of association.
	Growth of individualism.		
	American Revolution (1775).	Rousseau.	Democracy.
	French Revolution (1789).	Voltaire.	
		Kant.	Moral conduct judged by its motive. So act that the maxim of your conduct could become a universal law. Reason the authority.
		Schopenhauer.	Pessimism.
		Hegel.	
		Hume.	
		Bentham.	Good is happiness, and that of the greatest number. Eudomonists.
Florence Nightingale (1820-1910)	19th Century.		
	Emphasis on the good of society.	John Stuart Mill.	Utilitarians (Conduct judged by its effect).

Protestant Deaconesses of Keiserworth.		Comte.	Positivists. Empiricists. Intuitionists.
Founding of Nursing Schools.	U.S. Civil War (1861-1865)	Huxley.	Theory of evolution.
	Abolition of slavery.	Spencer.	applied to Ethics.
Organized Red Cross Societies American Red Cross (1881).	Theory of evolution, Darwin (1809-1882).	Wolff.	Do that which makes your state and that of others more perfect, and refrain from that which does not.
		Guyau.	Claimed that instinct- ive justice and love and fraternity influenced men in deciding what was moral conduct.
Beginning of many modern ethical ad- vances of a humane nature.		Bergson.	
		Dewey. Mackenzie. Bowne. Paulsen.	Books on ethics.
		Nietzsche.	
	20th Century.	William James.	Pragmatism.
	World War (1914).	Josiah Royce.	Philosophy of loyalty.
Higher educational standards in nursing schools.	Changing ideals.	Warner Fite.	Individualism.
	Advance in science, invention and ex- ploration.	Kropotkin.	Nature not a-moral.
		Bertrand Russell. Benedetto Croce. Santayana.	

Concentration exercises which have been an aid in teaching ethics to student nurses are those founded on the system of Jane Brownlee, a high school teacher, who taught that "thoughts are things" and who had students concentrate on an ethical quality or condition in order to achieve its realization.

One method employed by the writer has been the selection of a concentration word or sentence at the end of a lesson period to be used for concentration by the class until the next lesson, the students to watch themselves and others as to how they lived up to this ethical principle. The word chosen might be the ethical principle involved

in a problem which had been discussed, such as reliability. At the next lesson some student would relate an incident illustrating how this principle had been applied to conduct in some instance.

The qualities for which students are marked in their efficiency reports are suitable for this purpose, such as even temper, courtesy, etc. The concentration word or sentence may be suggested by the lesson assignment and have been emphasized in recitation. The Golden Rule, "right feeling, right thinking, right doing," democracy, the sacredness of human life, etc., have also been chosen.

Other concentration exercises with which the student experiments individually have been beneficial in improving a condition or the environment, such as health, success, harmony, etc.

Written reports by students at the end of the course have shown that the students quite generally consider these exercises of value, and they have described their personal experiences with them in detail.

Self-analysis with the incentive of character improvement does not appear to lead to self-righteousness or priggishness. We are more apt to be self-satisfied when we are critical of others than when we strive to behold

the notes in our own eyes.

Some methods in teaching ethics which have proven valuable are: The recitation method on assignments for reading; the problem method in the discussion of problems of a general or professional nature, the laboratory method in experimenting with concentration exercises in character improvement, practice in meeting the situations which arise in daily living, and practice in participation in government.

The importance of the subject of ethics to nurses is worth weighing carefully in planning the curriculum, even where the time element must be considered.

## Graduation

By Dr. GORDON JACKSON, Deputy Medical Officer of Health, Toronto.

It hardly seems possible that a year has gone since last we met to do honour and pay tribute to a graduating class and yet, in a rapid survey of the many subsequent events it would seem that years must have passed in order to permit of their occurrence.

The age in which we live is a network of kaleidoscopic incidents: A flash, an impression, and tomorrow but a memory; speed, action, accomplishment. And so today, we meet to celebrate the realization of visions formulated three short years, or three long years ago, according to the view-point of the individual, the culmination of earnest endeavour on your part, and it should be the day of days in your career. In the parlance of the soldier "you have gone over the top, you have attained your objective, and nothing remains now but to consolidate your position."

You are to be congratulated on your successes thus far. You have every right to your joy, your happiness and your pride of achievement. The dark cloud of pessimism has no place on an occasion of this kind, but it is only fair and proper that you should be prepared to meet eventualities. Trials, tribulations, worries and cares may come as surely as sunset follows

the sunrise. Life would not be life without them. The clearest diamond is but a bauble until subjected to grinding sands and the cutter's art. Adversity is but the tempering heat that toughens the steel within us. Remember that a ray of optimism will always dispel the cloud, and the sunrise will burst forth with increasing brilliancy.

In your enjoyment of your newfound freedom, that feeling of release from bondage, may your thoughts oft return to your Alma Mater. So regulate your conduct that no action of yours may reflect discredit on this institution, or on those in charge. And now you would sail away, like the mariner of old, into uncharted seas—the compass of knowledge, the barometer of hope, the anchor of faith, and the guiding star of ambition, your only equipment. The experience of some who have preceded you may be of benefit and assistance in piloting you through the shoals and shallows at the very commencement of your voyage. Many a good barque has foundered in the sea of life because of ignorance of hidden dangers, and if you would bring your voyage as a nurse to a successful termination, it is suggested that the following notations be incorporated in your log:—



## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
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### *The Interpretation of some Clinical Laboratory Studies*

By Dr. A. G. MCGHIE, McGregor-Mowbray Clinic, Hamilton, Ontario

The modern clinical laboratory has become a necessity to every physician who is attempting to practise scientific medicine, not that the laboratory is the one and only thing necessary for accurate diagnosis, for it is only one of the many aids at our command, the same as the x-ray, the sphygmomanometer, and the electrocardiographic machine. Like every other effort in the science and art of medicine, precision and accuracy in all laboratory procedures is most essential, for inaccurate work will give inaccurate results and be not only valueless, but worse still, will be misleading and a hindrance rather than a help. Reagents must be accurately made and checked, stains must be standard, and cleanliness of apparatus is very essential. This, however, all reverts back to the type of person doing the laboratory work. The technician must be properly trained, must understand the fundamentals of, and be keenly interested in his work, for no laboratory, no matter how well equipped, can be depended upon if the operator is lazy, careless, or indifferent. This, of course, does not apply to laboratories alone, but to all branches of medical science, nursing, and hospital management.

Many patients lose valuable time and considerable money by having clinical laboratory and x-ray laboratory studies done before they are studied from the point of view of history and physical examination. They put the cart before the horse, and

generally the wrong part of their anatomy is x-rayed, or laboratory studies that are not indicated are done and the essential ones, as far as they are concerned, are overlooked. As an example of this, I recently had a patient referred for an x-ray of the colon because of a history of blood in the stool. Usually an x-ray of the colon would be indicated, but physical examination revealed a large spleen. The white blood count was 158,000, and a differential white count gave a blood picture of spleno-myelogenous leukaemia. The history indicated that the bleeding was from low in the bowel and anoscopic and sigmoidoscopic examinations revealed a haemorrhoid oozing a slight amount of blood, because of the leukaemia. Should x-ray of the colon alone have been done the finding would have been negative, and the patient put to a useless expense. Physical examination caused one to suspect the true condition and the clinical laboratory confirmed the diagnosis.

As private duty nurses, then, when your attending physician requisitions certain laboratory work, he does so for the purpose of confirming an opinion or to rule out a possibility. Thus a report of normal findings may be of just as great value in a given case as one of abnormal findings.

#### *The Blood*

I would like first to discuss the blood and some of the important examinations of it. The blood is a colorless fluid media in which float various kinds of solid bodies. The red corpuscles are so numerous that they colour the whole blood red. They are

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for the purpose of carrying oxygen to all parts of the body. Haemoglobin is an iron compound found in the red corpuscles which unites with the oxygen in the lungs and sets it free where it is required in the body tissues. The polymorphaneuclear leucocytes, a portion of the white cells, are the scavenger cells, whose duty it is to attack invading bacteria. Lymphocytes, also white cells of different appearance and character, are found in the normal blood in small numbers, but may be greatly increased in patients suffering from any of the leukaemias. The normal red cell count is from 4,500,000 to 5,000,000; white cells 7,000 to 9,000. Haemoglobin around 80%, and the blood platelets, which have to do with the clotting of blood, should be between 250,000 and 500,000.

A red cell count and a haemoglobin estimation is done to ascertain whether or not an anaemia is present, and if present, the degree and character of the anaemia. The white cell count, I do not believe, is complete without a differential count. In acute infections such as pneumonia, appendicitis, or sinusitis, the white count is increased, but that increase is in the polymorphaneuclear leucocytes or scavenger cells. If the white cells are increased, say from 8,000 to 20,000, with the percentage polymorphaneuclear cells predominating, then one may be sure that a very active inflammation is going on somewhere in the body, and that it is due to one of the pyogenic bacteria. If, however, the count is 20,000, and half or three-quarters of these are lymphocytes, myelocytes, etc., then one must conclude that there is a grave disturbance of the lymphatic tissues of the body. In purpura, in which bleeding is one of the prominent symptoms, the platelet count may be found very low. We have a thirteen-year-old girl in the hospital at the present time suffering from purpura, whose platelet count on admission was 1,300, and after a transfusion of six hundred cubic centi-

metres of blood the platelet count only reached 9,000. The platelet count in this case confirmed a diagnosis which one suspected but could not be certain of without it.

As we have mentioned transfusion, let us discuss for a moment blood grouping or blood typing. Before any transfusion the bloods of the patient and donor must be typed. The donor's red corpuscles must be placed in the patient's serum, and the patient's corpuscles in the donor's serum. The following things may happen to render a donor unsuitable. The patient's serum may agglutinate, or cause a bunching together of the donor's red cells, or the donor's serum may do the same thing with the patient's red cells, or the serum of either might cause a destruction of the other's red cells. It can easily be seen that to have two such antagonistic bloods in one patient's body would be a calamity. Therefore a donor is chosen whose blood cells and serum are in harmony with the patient's red cells and serum. This typing is the work of the clinical laboratory and will again emphasize the need for accuracy, as any error might easily result in loss of life.

There is much more, of course, to the blood than a fluid media, and corpuscles and platelets. The chemical constituents of the blood are very interesting and very essential to health and life. The estimation of the sugar content of the blood is indispensable in diabetes. The sugar content is calculated on the whole blood, corpuscles, serum and all, so that the blood when taken is mixed with a small amount of oxalate, which prevents clotting. The normal blood sugar ranges from .09% to .12%, even .14% may not be abnormally high in a given case. Some patients will show sugar in the urine with a blood sugar slightly above normal, while others will show only an occasional trace of sugar when the blood sugar is three times the normal. It is not the sugar in the urine that is harmful in diabetes, but the abnormal amount of sugar in the blood.

I admitted a patient to hospital recently who showed only a trace of sugar in the urine but had gangrene in both great toes. She had been on a good diet and some insulin prescribed by her family physician, but her blood sugar was .29%. With this blood sugar it was unreasonable to hope for any improvement in her gangrene, and repeated blood sugar estimations were necessary to determine the amount of food and insulin required to start this patient on the road to recovery.

The blood contains certain waste products from food and burned out body tissues that are eliminated by the kidneys; namely, urea nitrogen, urea, and creatinine. If the kidneys are impaired so that this refuse is retained, something must be done about it. These tests are also done on whole blood and are found to be elevated in various forms of nephritis. The normal urea content of the blood is from 25 to 35, urea nitrogen 12 to 15, and creatinine 1.5 to 2.5. The former two rise more rapidly and fall more quickly than the latter. I have many times seen a patient with a urea nitrogen of 160 and over, and occasionally a creatinine of 25, but I have never seen a creatinine that high in a patient who did not succumb.

The blood chlorides are of interest possibly, especially to those doing surgical work. A number of years ago patients with obstruction of the bowel or persistent vomiting were thought to develop acidosis when really the opposite condition, alkalosis, is what overcomes the patient. The blood chlorides fall very rapidly and can be replaced by giving intravenous saline (sodium chloride). This, along with glucose, as a nutrient, is saving many lives today.

There has not yet been developed a satisfactory method of estimating the calcium content of the whole blood, but the calcium content of the blood serum is readily estimated, and the normal reading is from 8 to 10 or more. Many cases of delayed union or

non-union in fractures is due to a low blood calcium. Calcium cannot be laid down to form new bone if it is not present in the blood. Tetany, muscle spasm, etc., that occasionally follow disturbance of the parathyroid glands, during thyroidectomy, is due to a low blood calcium. These glands appear to control the calcium metabolism of the body. The blood calcium may be increased by giving cod liver oil, foods rich in calcium, natural or artificial sunlight and parathormone, an active principle of parathyroid gland, isolated by Dr. Collip of the University of Alberta.

The Van der Berg reaction is also done on the blood serum. By this laboratory test one is able to discover bile in the blood, even before there is any clinical appearance of jaundice. The physician may suspect liver damage and by this test he may prove for himself that certain abnormal conditions are going on in the liver, or that a patient who has the appearance of jaundice is icteroid not because of liver damage but because the blood is being destroyed by some agent and the blood pigment is deposited in the tissues.

The sedimentation test on the blood is one of the newer tests and is done in this way. A small quantity of blood is mixed with oxalate to prevent clotting and placed in a standard sized tube. The blood cells gradually settle out, and the rate at which this takes place is an indication of the resistance of the patient to his disease. If the red cells settle out quickly, it indicates poor resistance, while if this takes place slowly it is evidence of good resistance and gives a better prognosis. Repeated sedimentation tests on the same patient will give one a lead as to whether the patient is winning or losing in his battle against disease.

The Wasserman reaction, of course, is a test for syphilis. A single test giving a slightly positive reaction is not conclusive evidence that syphilis is present nor is a negative report positive proof that it is absent.

### *Spine*

The examination of the spinal fluid is important and the information gained from a spinal puncture starts first with the observation as to the amount of pressure in the spinal canal. Spinal fluid is normally clear, but in injury to the brain or spinal cord it may contain blood. In meningitis there may be enough pus cells present to make the fluid turbid. Normally the cell count in spinal fluid is from 1 to 7, and any increase over this indicates irritation of some sort within the skull or spinal canal. An increase in globulin indicates the same thing. A Wasserman reaction and colloidal gold or colloidal ben-zadine test informs us as to active syphilis of the nervous system.

### *Stomach*

Let us now turn to laboratory examinations of the stomach, remembering that the x-ray of the stomach is an invaluable procedure in so far as it goes. The x-ray will give us an idea of the size, shape, and position of the stomach and first portion of the duodenum, as well as any change in the anatomy of those organs; that is, the presence of carcinoma, ulcers, diverticuli, and syphilis, but it can give no information as to the physiology or functional capabilities of the stomach. This must be learned from gastric analysis. This test, as it is usually reported, tells us how much acid, if any, is present, and if blood is found it is mentioned. If this is all that is learned from a gastric analysis it is scarcely worth the time and trouble to the patient and operators. The first information is gained as soon as the tube enters the stomach and the overnight contents withdrawn. If food is present in the specimen even micro-

scopically there is stomach retention and this is more accurate than x-ray observation can be. Then the test meal is given, and portions of it are withdrawn at fifteen-minute intervals for two hours, with certain observations made on each specimen obtained. In a normal stomach the third or fourth specimen will be milky in appearance. Where acid is low or absent, the fluids leave the stomach quickly and the solid part of the meal is left behind. At the end of two hours the stomach should be entirely emptied and should contain only a small amount of the meal. If there is considerable of the meal remaining one knows that there is delay in the stomach emptying. After all specimens collected are filtered they are tested for free hydrochloric acid and total acids. In the normal stomach, the acidity when the meal is first taken is low, but with each specimen it increases up to a certain point, and then falls so that at the end of two hours it is the same as it was on starting. This is true also of any lesion within the stomach. The acids may start higher, and be very high at the end of one hour, but they fall again to the starting point unless, of course, the pylorus is obstructed and the stomach cannot empty. Thus a normal acid curve and a curve from a lesion in the stomach are similar. Lesions from without, but which affect the physiology of the stomach, may be duodenal ulcer, gall bladder disease, appendicitis, or other intestinal irritation or nervousness. With any of these the acid contents of the stomach does not fall to the starting point at the end of digestion. They may fall slightly or continue to rise even when the last specimen is withdrawn. This information is very important from the diagnostic standpoint.



## Department of Public Health Nursing

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### *Mental Health in Industry*

By MURIEL McKAY, Reg.N., Industrial Nurse, Hydro Power Commission, Toronto

Health has been defined as "That condition of the body which exists when the body is meeting adequately and without pain or damage, the demands of the moment, viz., a healthy body is one fully equipped to meet easily and well, all ordinary demands." We would consider, therefore, that the mentally fit industrial worker is one who having a competent knowledge of his work is able to carry on satisfactorily to his employer and himself.

The foundation of mental health in industry is laid long before the individual commences his first job: the right environment at home with its discipline and training, and the attendant school education should provide in the normal person poise and help for industrial life, but how frequently are we told by youthful workers that they have had a nervous breakdown. When the public generally and parents particularly, are educated to the viewpoint that a nervous breakdown is a mental breakdown, they will not be so keen on claiming this apparently interesting occurrence in their health history.

It is a well-known and accepted fact that sickness causes much more absenteeism in industry than do accidents. To what extent mental conditions contribute to this sickness (with its attendant loss to employer and worker) it is difficult to say, but we know that it plays a part, whether producing the ill health or being produced by it.

Industry has done much to protect its workers from industrial hazards, and is now attempting to promote health, hoping by education to affect the entire living of the workers, and at least by concrete measures, make life as healthful as possible during the

time that is spent within its plants. In this effort to create conditions favourable to industrial health, certain factors affecting mental health present themselves, and are worthy of consideration in any honest endeavour to promote healthy minds in healthy bodies.

Let us briefly consider some of the conditions in industry contributing to mental health: Physical examination of new employees with routine follow-up examinations, assures the workers of not being placed at unsuitable physical labour; for example, to mention two not uncommon conditions, the sufferer from cardiac disability or hernia, will not be put at a heavy job which might aggravate his condition, and is thus protected from a hazard which would imperil his chances of steadily working. In this way, is eliminated the worry that is present, when placement is not considered.

The contented worker is one who is performing a work he enjoys, and to place round pegs in round holes is an important point in maintaining mental health in industry. For example, we might cite the case of the outside worker who upon being injured and rendered unfit for the type of work he has done previous to his accident, is given (in the effort to rehabilitate him) a training at indoor clerical work. A position is secured for him, and he carries on at it, but ineffectively for both himself and his employer. A further study of his case suggests his return to outdoor work as a truck driver, he is found able to do this satisfactorily for his employer and happily for himself.

The next point, and the one which probably looms largest in the minds of those considering the mental health

of workers, is the question of sufficient pay. Continual dissatisfaction with the wages received, produces a mental slant that is bound to affect one's work detrimentally: probably no one is ever paid at their own valuation, but a decent living wage with hope of advancement, most certainly contributes to the mental health of alert ambitious workers.

The industry that carries with its employees, a sick benefit, pension, or insurance plan and so assures the employee of provision during sickness, in his old age, or for his family should he die, is greatly contributing to the mental health of its workers. These schemes produce the same reaction as does our Workmen's Compensation which in providing for the worker during the disability period following industrial accidents, guarantees him adequate care and a living wage while disabled from his accident.

In our efforts to preserve mental health we cannot avoid paying some attention to that well-known green-eyed monster jealousy; back of much unrest both in great and small occurrences this condition will be found lurking, and producing a state, harmful to the mental poise and happiness of numbers of persons. The removal or alleviation of this condition would tax the wisdom of a Solomon. Nevertheless, if we are sincere in our endeavour to produce and maintain mental health, it cannot be ignored.

In closing, may I recapitulate the points which would appear to be fundamental in a study of our subject—"Mental Health in Industry":

1. Early environment.
2. Education.
3. Proper placement.
4. Adequate wages.
5. Employees benefit plans.
6. Consideration of esprit de corps.

### *Mental Health in the Hospital*

By GERTRUDE P. GARVIN, Reg.N., Superintendent of Nurses,  
Isolation Hospital, Ottawa

It is claimed that the success of the Public Health Movement waits upon progress in the control and prevention of mental and nervous disorders.

The late Dr. Thomas W. Salmon, Professor of Psychiatry of Columbia University, has said, "In the campaign against disease the nurse is not merely an agent for the alleviation of suffering, but is also the most powerful force at our disposal, for its prevention and control. The nurse is already obtaining wonderful results by implanting in children the simple basic habits of bodily health. She cannot longer ignore the opportunity that lies before her in the detection and prevention of mental disease. Education in the laws of mental health and training, in good mental habits, will of course be the most constructive form of effort to reduce the burden of Mental Disease."

Knowing the status of Dr. Salmon as an authority in the realm of Psychiatry, this tribute to the nurse is impressive, and comes as a challenge to those intrusted with the education and

training of the efficient nurse of the future. All institutions interested in preparing young women to lead productive and happy lives, are giving more scientific and careful thought to the planning of a programme designed to produce the highest degree of mental and physical health possible.

A preliminary course in which the principles of mental and physical health are studied, should be a great aid to the student making her adjustment in the school. May I indicate here some factors which I feel must be considered essential to the development of mental health of the student.

There should be opportunity for participation in some form of recreation—tennis, swimming, basket-ball, dancing, etc.; but preferably competitive sports that broaden interests and social contacts and develop a spirit of good sportsmanship.

The cultural life of the student should be developed by direction of interests in music, books, current events, art.

The provision of some opportunity for a free discussion of her problems—loneliness, worries over mistakes and other difficulties, advice as to matters of dress, shopping, friendships, etc.

This can best be afforded in the provision of a house mother—not necessarily a nurse—but a woman of culture and experience who directs the social activities of a school and is a safe confidante and guide for the young student.

We realize more and more that physical and mental life are interdependent and that mental or social health means the ability to get on with one's fellow-men and live in proper adjustment to one's environment.

The nurses must be taught that not only do physical and chemical factors cause ill-health, but often there are psychic factors which are much more powerful influences in producing ill-health than either of the other factors.

Nurse students must be given an insight into some of these psychic factors to understand many of the peculiar behaviour reactions in their own lives as well as in those of their patients. They must understand that hysteria and neurasthenia are social diseases which are caused by the maladjustment of the individual to his environment.

We know that an emotional upset may bring about nausea, vomiting, weakness, chills and headache. These manifestations, the student should understand, are merely the outcome of emotional conflict.

The newer aspect of the improvement of health and happiness is to approach the problem from within. Complete honesty in dealing with ourselves will help to keep our mental life better balanced. In other words, we must face the fact of our inadequacies and faults without a sense of inferiority and with a sense of humour that helps one to laugh at one's self.

With psychiatric training the nurse learns to control her own emotional reactions, she does not betray her worries or lose confidence. She must have good emotional control in order to give the patients confidence. Above

all, she learns the value of truthfulness in dealing with the patients.

The advantage of such education, to student, patient and hospital, are inestimable and will make for greater harmony.

Incidentally this instruction will furnish the best possible background for the course in psychiatric training, which we hope will be one of the developments of the near future. The nurse will take to this part of her course vision and quick, keen discernment, intelligent sympathy and the power of sensing and defining accurately. She will learn that in many sick rooms the patient may be more important than the disease. Bad habit formations may appear which are more serious than wounds. These habits must be modified.

When we consider that more than fifty per cent of all persons presenting themselves to physicians or to hospitals as sick, show no physical or organic cause for their complaints, but are instead suffering from social or mental mal-adjustments or psycho-neurosis, we are faced with the urgent necessity of preparing the student as early as possible in her training to help in their care. Regarding education, I should like to suggest that collegiates and high schools be asked to consider special courses in Mental Hygiene in the third and fourth grades for those students contemplating a nursing course. This to be later supplemented by instruction in the preliminary course in the hospital training school and clinical observation of patients suffering from psycho-neurosis and other nervous disorders.

Approaching the problem in this way with an honest recognition of such disorders as mental diseases and an intelligent sympathetic management and care of them as such will be of inestimable value in removing the stigma and prejudice against psychiatric nursing now held by many—perhaps most—nurses, and will as well greatly assist in the early detection of mental illness and resultant improvement in the prognosis for the patient.

## *Mental Health in the Home*

By Miss ISOBEL McINTOSH, Reg. N., Hamilton, Ont.

Illness has been defined as "the result of physical, mental or social mal-adjustments, and nursing implies, the care of the whole patient, who is a complex human being," therefore, emphasis must be placed on that mysterious composition of elements called the mind, which controls the body in all its actions and reactions, either in health or disease. The visible results of our thoughts are seen in our actions and emotions, but as our thoughts are silently controlled by our will, we have great need of a better understanding of the forces whether from heredity or environment, that influence the trend of our own or some other person's will.

The newer clinical laboratory discoveries insist that pathology and psychiatry go hand in hand. It is a recognized fact that disturbed metabolism interferes with the mental mechanisms which control the emotions of human beings. The same emotional symptoms relative to the physical diseases are more of a nursing problem than the actual disease, because the physician decidedly prescribes for the disease, while the nurse is left for twelve hours of the day or night with the apprehensive patient. The technical efficiency of the nurse is greatly handicapped if her mental attitude is not in harmony with that of the patient. Such attitudes may be quickly changed by suggestions of more favourable qualities, depending on the elasticity of mind and power of will to use all the tact the occasion demands. This proves the necessity of equipping every nurse with some knowledge of the fundamentals of human behaviour.

Modern psychiatrists tell us that mental states are classified according to the kind of elements that compose them, and it is the change in the proportion of these elements that characterizes mental differences. Perception and imagery are the most important of the primary state, while in the secondary state, emotions are

the most primitive. Sentiments are the least important type, whereas rational thought is the most essential factor in the highest development of mental life.

According to Howard C. Warren, of Princeton University, the development of mental states is due to the co-operation of three factors. 1st—The complex inherited cortical structure. 2nd—The specific forces in the general environment which act upon the given individual. 3rd—The social environment. All three factors vary with different individuals, and in different situations. From this we find that the extent of knowledge which can be absorbed by the individual depends on heredity, but the amount that will be learned depends on environmental influences. Thus, while the growth of individual mentality is the essential part of life's business, fateful circumstances play a positive part in directing the path of life's experiences, and fate is rather ironic at times, in placing the uncertain mind in an unfavorable home environment. Immeasurable harm comes from the lack of understanding on the part of those in authority, whereas if correct conditions were created or adjusted, this same individual might become a potential influence for good in the community, or at least a border-line sanity would be maintained.

In looking to the ideal home, as the primary foundation of the progress of the nation, our hope must be placed on the harmonious development of character, intellect and temperament of the individual members of families. All life is a school where from the early months of infancy, guidance and discipline controlled by common sense, exert the most formative influence for good behaviour.

The forces of modern civilization bring many complications to imperil the correct balance so necessary to mental health. A moderate display of expressive emotions is necessary for the stimulation of vital life, and is



a great force for civilization. It is the extreme manifestations that disturb the balance. From the normal error to the destructive disturbance there are numberless steps of transition.

Of paramount importance in many homes today is the problem of worry and restlessness, each in itself suggestive of the destruction of the happiness and achievement of the two generations that compose the family life. There is an endless competition for the non-essentials of life, and all this in spite of the fact that neurologists claim that every person has a tendency toward neurasthenia.

The registered nurse goes into any representative home, called hither by the illness of one of its members, but immediately she steps across the threshold she becomes responsible for the mental atmosphere. It is well for her if her knowledge and perception express the resourcefulness necessary to deal wisely and sympathetically with the mental variations even within the limits of normal life.

This may be the great opportunity to direct the thoughts of the members of that home, to even a few of the important factors that contribute to the maintenance of mental health. It is an undisputable fact that time must be allowed for sufficient rest and sleep, because the decomposition of the brain molecules cannot be restored in any other way. Among the manifold demands of modern times, there is a great need for quiet, reasonable thought, so that the strength of will remains strong and independent. To have the power of forced attention or concentration, is to have the fundamental principle of human pro-

gress and success. The development of courage and endurance has saved many a seemingly disastrous situation. "Tis the front toward life that matters most: The tone, the point of view, the constancy, that in defeat, remains untouched and true." While it is important that our work should be suited to our ambition and ability, there must be no relaxation of the spirit necessary to maintain our economic independence. All effort should not be measured by the usual standards of commercial value, but rather, by the sentiment expressed by R. L. Stevenson—"In the joy of the work, lies the sense of the action". That to miss the joy of work, is to miss all. Human behaviour, at its best, has the golden thread of humour running through all work and play.

To have the personal ideals of the master mind of Sir William Osler given to us, in one of the most distinguished lives in modern history, is in the deepest sense of the word, a liberal education in mental health, and demonstrates the simplicity of greatness.

(1) To do the day's work well and not to bother about tomorrow.

(2) To act the golden rule, as far as possible.

(3) To cultivate such a measure of equanimity, as would enable one to bear success with humility, the affection of friends without pride, and to be ready when the day of sorrow and grief comes, to meet it with courage, befitting a man.

"I have loved no darkness,  
Sophisticated no truth,  
Nursed no delusion,  
Allowed no fear."

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## *Home Nursing Training*

By ANNE ANDERSON PERRY, Toronto.

In the last five years, through the capable work done by provincial supervisors of home nursing, the Canadian Red Cross Society has been able to command the services of small armies of doctors and nurses who have gratuitously instructed no less than 14,000 girls and women in this indispensable household art. If there were enough instructors this number might be doubled within a year. But even as things are it can be readily seen that with an allowance of only three to an average family, the instruction thus extended has already reached at least fifty thousand persons whose health standards have been thereby beneficially and permanently affected.

When, however, such large centres of population as Montreal, Toronto, Winnipeg or Vancouver are contemplated, it is driven home that the surface only has been scratched and that there are many new fields to conquer before the Red Cross can fulfill its ideal of carrying into every home a working knowledge of the science of home nursing, without which neither wives or mothers may be said to be adequately equipped for their life work.

It is learned that of all these cities, Toronto has done most to bring within the reach of all classes of women the necessary instruction and from Miss Goodman, the busy supervisor for Red Cross Home Nursing, information is forthcoming which shows the remarkable progress already achieved in that city.

Since 1924, when classes were first formed, Miss Goodman has organized 232 groups within Greater Toronto, 214 of which were completed with a total of 4,105 members in attendance. So insistent indeed is becoming the demand for home nursing instructions that it is now necessary to

organize at least 50 to 60 new groups each year and a glance at the subjects taught reveals why women are so glad to obtain it, from sources so authoritative as the expert nurses or medical men in charge.

The course consists of twelve lectures and demonstrations on personal and home hygiene; the bedroom, in health and sickness; signs of illness; care, feeding and treatment of the sick; communicable diseases; emergencies and slight ailments; maternity and infant care; feeding the infant or child; food needs of the adult.

A course so obviously helpful to women of all classes that it is scarcely surprising to learn that women in the hundreds of groups already instructed have been drawn from many departments of life, including private homes, stores, factories, settlements, institutions for unfortunate or delinquent girls, offices, clubs, hostels for the newly arrived immigrant girl, the Y.W.C.A.'s, the Canadian Girls in Training, colleges, home and school or business and professional women's associations and the day nurseries. But it is somewhat astounding to learn that even such institutions as care for the deaf and dumb or the blind as well as those organizations which keep in close touch with foreign women from such countries as Germany, Russia, Poland, Ukrania or China also are demanding home nursing instruction for their charges.

"What! Teach home nursing to the deaf, the dumb, and the blind, or to the Chinese women!" you exclaim. "How can you do that?"

"By just doing it," you are told by Miss Goodman. "One of the most enthusiastic, interested groups ever taught in Toronto consisted of eleven deaf and dumb young married

women who were keen to take the course. Of necessity it was harder for the nurse in charge, as everything she said or did had to be rapidly and accurately put into sign language by a devoted woman interpreter, but it was amazingly cleverly done. We have never handled a class which became more efficient and as many of the women had children—yes, in some cases quite normal children with all their faculties—these young wives were every day finding use for the knowledge they had gained.

“The blind students were an even more difficult group, but as the course was requested by the inmates of Clarkewood Institution it was given in an adapted form. The students were intensely interested, soon became expert bed makers and seemed to be greatly benefitted.

“As for the Chinese women, we have never dealt with a more intelligent group. There were twenty of them in all so that they represented a good proportion of the sixty-five wives who have been brought to Toronto from China by their husbands, under the five hundred dollar head tax. They were all mothers of families and of good class. Among them was Mrs. Chew who acted as a clever interpreter, and Mrs. Wo, the wife of a Chinese United Church minister, now in the city of Victoria in charge of a church. Then too, a Miss Ing, a Chinese lady who attends one of our medical colleges, came to give a demonstration and lecture. The women brought their children with them and allowed them to be used in demonstrating baby or child care. As these Chinese women and children were never allowed on the streets alone it was necessary that all members of this unique class should be brought to the church where the classes were held and taken from it to their homes. Through the generosity of a mission

worker who used her own car for this purpose this was done for the entire series of lectures so that this group completed the course with a full attendance. It was in charge of a highly capable nurse from the children's hospital who was proud of the results.

“Then at the mission on Robinson Street where there is that devoted woman, Miss Maybee, who gives all her time and talents to the assistance of the foreign women within the city gates, we undertook the instruction of groups which were quite international in character, and polyglot as to language. But with Miss Maybee, as well as some of the students themselves assisting, we were able to give the most important parts of the instruction to them all. Such another group was handled through the Y.W.C.A. and in that one, as many of the girls were employed at domestic service they had to take their afternoons “off” to come to the classes. But they seemed eager to do so although they represented foreign lands as Russia, Poland, Ukrania, or Switzerland.

“Another group of women who always seem pitifully anxious to receive the home nursing training consists of the mothers who have to leave their children at the day nurseries and creches. These women, though they have to work hard every day, will cheerfully come in the evenings once a week in order to take the course. They see in the nurseries what it means to have expert care for their children and they are themselves anxious to acquire the requisite knowledge.”

It was also learned that the large insurance companies have been so interested in home nursing courses, for girls and women, that several of them have co-operated with the Red Cross to supply assembly rooms in which their employees may receive instruction and year after year have provided tea for those taking the

training in order that they can at once enter the classes after their day's work. A significant fact. For it is apparent that these companies which are vitally concerned with the conservation of life see in this instruction for women one of the most powerful agencies in that preventive medicine which it is their business to encourage and to advocate.

Still other evidences of the increasing demand for home nursing knowledge lie in the fact that no less than fifteen home and school clubs in Toronto have asked for, and received the course, while dozens of churches, particularly in down town sections, have very clearly shown that in Red Cross home nursing training they recognize one of their most valuable allies in teaching the way of right living to many of the under privileged custodians of homes and children.

Other cities in Canada are making progress toward extending a knowledge of home nursing but there are still many virgin fields to conquer in both town and country, which await only a small army of professional instructors and the necessary finance in order to make this special train-

ing available to still more Canadian women.

It is recorded that in New Brunswick, where Miss Sibella Barrington, the provincial organizer, has done invaluable work throughout her territory in the widespread organization of home nursing classes, one group of women were so determined to take this training that although they were heads of households, they undertook an intensive course of two weeks with daily attendance rather than miss the chance offered by an instructor who could give only that period to the work.

Women of all classes and in all parts of Canada are eager for this training which they recognize gives them a knowledge of those things most essential to successful wifehood and motherhood—knowledge of the fundamentals of family health and well-being. In attempting to fill this need the Canadian Red Cross is meeting an individual as well as a national demand, the value of which may be estimated only in terms of human happiness and health.

(Published in "Social Welfare," November, 1928, and in the Labour papers throughout Canada.)

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## *Announcement of Change in National Representatives to Congress*

There have been two changes made in England's representatives to the Congress: the Misses Ellen F. Brownsdon, S.R.N., F.B.C.N., and Susan A. Villiers, S.R.N., R.F.N., F.B.C.N., are replacing Mrs. Lancelot Andrews and Miss Helen Pearse.

Miss Ellen Brownsdon is a director of the National Council of Nurses of Great Britain, and sister in charge, Treatment Centre, London County Council School Nursing Service.

Miss Susan A. Villiers is a member

of the General Nursing Council for England and Wales; president of the Infectious Hospitals Matrons' Association; vice-president, National Council of Nurses of Great Britain; vice-president, British College of Nurses.

There is also a substitute for Denmark. Miss Petria Andersen is unable to attend the Congress, and is being replaced by Miss Ellen Brae, who is working at the Medical Centre of New York.



## News Notes

### BRITISH COLUMBIA

The regular monthly meeting of the Vancouver Graduate Nurses Association was held on June 12th at the Vancouver General Hospital, Miss M. Campbell in the chair.

The private duty nurses brought forward the question of the ten-hour day, and a committee was formed to go thoroughly into the matter.

The chairman referred to the resignation of Miss K. W. Ellis as lady superintendent of the Vancouver General Hospital, and expressed the deep regret of all members of the Association, who at the close of the meeting presented her with a leather purse bag.

Mr. Filmer, physical director of the Y.M.C.A., gave an excellent address on "Health, and its connected relation to the Mental, Spiritual and Physical sides of life." After a vote of thanks to the speaker, the meeting adjourned.

**EXAMINATION FOR CERTIFICATE OF REGISTERED NURSE:** The results of the Examination for Certificate of Registered Nurse, to be awarded on completion of hospital course, which was held in various centres of British Columbia recently, are as follows, names being given in order of merit:

80% to 90%: Misses E. O'Brien, St. Joseph's Hospital, Victoria; K. M. MacMillan, Vancouver General Hospital; E. N. Dickinson, King's Daughters' Hospital, Duncan; W. M. Mole, Vancouver General Hospital; D. M. Reed, Vancouver General Hospital.

75% to 80%: Misses M. E. Johnson, C. E. Bower (J. E. Coogan, E. O. MacMaster—equal), I. L. Blackman, G. F. Lee, M. I. Scott, J. A. Campbell, M. A. Blake-more (D. M. Handley, R. Johnson—equal), I. I. Jones.

70% to 75%: Misses M. A. Wright, K. P. Dayton, E. M. Welton (D. M. Hall, M. F. Weaver—equal), E. I. Fetterly, M. Lindsay, E. B. Casswell, M. C. McDougall, B. Stark (A. M. Beacham, M. Moore—equal), N. E. McNinch, A. F. Dickman (F. V. McKibben, H. K. McKinnon—equal), (A. J. Cole, B. L. Martin—equal), M. M. Stirling, N. S. Strathee, B. M. Forsberg (R. DeGear, E. R. Thompson—equal), (O. E. Dirom, L. M. McLaughlan—equal), R. E. V. O'Neill.

60% to 70%: (A. L. Groves, G. J. Morley—equal), H. K. Gibbs, I. M. Clark (L. M. Andrews, M. J. McKay, M. Morrison—equal), N. Bonar (V. L. Bird, I. M. Stokes—equal), (E. L. F. Charbonneau, E. M. Rayburn, M. C. Williamson—equal), K. Tingle, (E. E. Hutchison, A. Levasseur, J. H. Woodworth—equal), (M. E. McGrattan,

N. Mitchell—equal), (E. Caron, M. B. McDonald—equal), (H. M. Bell, E. M. Larky—equal), (L. M. McCormack, J. H. McMurphy—equal), H. M. Voorhees, E. L. Connor, C. M. Mulhern (E. C. Bell, L. E. C. Hembling—equal), E. Hannam (V. V. Jones, A. L. Poole, L. E. Senay—equal), M. G. Johnston, R. E. Westoby (K. F. MacDonald, H. A. MacMillan—equal), G. P. Stimpson, A. M. Kilgannon (M. V. Doroshenco, G. A. Miller—equal), (A. Aitchison, D. M. Brown—equal), L. O. Wyatt, M. E. Snow, J. M. Heathorn (E. K. L. Dimock, C. E. C. Sanderson—equal), B. K. Geddes, B. M. Allaire (E. H. R. Homersham, S. A. Peat—equal), E. M. Greenway, C. L. J. Clark, C. A. McDonald. 50% to 60%: Misses I. A. Hamilton, D. M. Brewster, C. R. Duff.

Passed Supplementals: Misses L. A. Ball, C. M. Bawtinheimer, I. E. Dynes, E. G. Fiddick, J. M. Hardy, H. O. Lipsey, L. A. Morrison.

With Supplemental Examination to write: Misses D. Forde (1), C. M. Hardie (1), E. M. C. Jackson (1).

### MANITIBA

**GENERAL HOSPITAL, BRANDON:** The Graduate Nurses Association entertained the graduating class at dinner May 14, at which Mrs. A. V. Miller presided. Following the dinner, a programme of music, readings and toasts was given.

Twenty-six nurses received their diplomas on May 16th, at the graduation exercises presided over by Mr. R. Darrach, president of the Hospital Board. Dr. J. S. Clark addressed the class on "The Training of Nurses in Community Health Work". Prizes and medals were presented to: Miss E. M. Bright, gold medal for highest standing in her year, and the prize for the eye, ear, nose and throat; Miss Kains, Dr. Edmison's prize for obstetrics, and bronze medal; Miss G. M. Birtles, silver medal; Misses M. R. Palmer and M. E. Perry, general proficiency prizes.

At the conclusion of the exercises a reception was held in the newly-erected nurses' home, at which the class received with Miss Macleod.

Miss E. McNally, assistant superintendent of nurses, has left for the East to recuperate.

Miss Mary Houston has been appointed Public Service Nurse, Brandon, under the Provincial Board of Health.

**MENTAL HOSPITAL, BRANDON:** The annual graduation exercises took place on May 15, when the following received their diplomas in mental nursing and first aid: Miss Evelyn N. Innes, of Deloraine; Miss Lucienne Leocot, of Ste. Rose du Lac; Miss Martha McClintock, of South Barsalloch, Scotland; Miss Myrtle

M. McTavish, Rapid City; Miss Mabel Pilkey, Alexander; Miss Islay Riach, Portage la Prairie; Miss Margaret Smith, Kelwood. The event was presided over by Hon. D. G. McKenzie, and the main address to the graduates given by Dr. Wm. Boyd, professor of pathology at the University of Manitoba.

Dr. Barager, superintendent of the Hospital, has returned from post-graduate work in England.

**ST. BONIFACE HOSPITAL:** The Alumnae entertained at a silver tea, April 13, which was most profitable.

Commencement exercises were held on May 16, when forty-eight nurses received their diplomas. Dr. E. J. Boardman delivered a very interesting opening address, followed by several vocal selections and addresses to the graduates by Dr. A. J. Adamson and His Grace Mgr. A. Beliveau. Prizes were awarded as follows: general proficiency, Florence M. Howson; practical nursing, Susanna E. Indridsson; surgical nursing, Mina E. Cairns; obstetrical nursing, Emma M. Kunemon; charting, Gertrude A. Hunt; bandaging, Kathleen E. Flanagan; executive ability, Gladys M. Thornton; highest standing in theory, Gene E. Hooper.

Miss S. Wright, president of the Alumnae, returned to Winnipeg after having spent the past month in New York.

Miss W. Tracy, who has been doing private duty nursing in Chicago, is visiting her sister, Mrs. Leglyn, of Winnipeg.

Miss Didion, who has undergone an operation in the Misericordia Hospital, is improving.

Miss O'Rourke has accepted a staff position at the Deer Lodge Hospital.

Miss E. Payne returned to Winnipeg after having spent the past month at the home of her parents at Dauphin, Man.

Miss Gladys Huggins left for Detroit, Mich., where she is doing private duty nursing.

Miss Emily Smith has accepted a staff position at Ninette Sanatorium.

**GENERAL HOSPITAL, WINNIPEG:** Miss Millicent Gostling (1928, H.S.C., Gt. Ormond St., London, 1924) will attend the I.C.N. Congress, Montreal. She is now visiting friends in Chicago, and will motor to Montreal from that point, arriving in time for the opening session. At the close of the Congress the party will visit Toronto, and spend four or five weeks motoring through the New England States, camping at various points on the shores of the Great Lakes.

### NEW BRUNSWICK

The Council of the New Brunswick Association of Registered Nurses met at the Saint John Tuberculosis Hospital on May 14, 1929, with the president, Miss McMaster, in the chair. Miss M. Murdoch was appointed to arrange for a provincial exhibit at the International Congress. Arrangements were made for the annual meeting of the Association to be held in Saint John, September 17 and 18. Reports of the various committees

were presented, and much routine business dealt with. At the close of the meeting, refreshments were served by Miss Coleman, superintendent of nurses at the hospital.

**SAINT JOHN:** The monthly meeting of the Saint John Chapter of Registered Nurses was held May 20, at the Saint John County Hospital, with the president, Miss E. J. Mitchell, in the chair. Plans for entertaining the provincial convention on September 17 and 18 were discussed. At the close of the business session a social hour was enjoyed and refreshments served by Miss Coleman, superintendent of nurses at the hospital.

The Chapter also held the first of a series of bridges on April 18. The purpose was to raise money for the Stammers Memorial Fund to furnish a ward for boys in the new hospital. A most enjoyable and profitable evening was spent.

**GENERAL PUBLIC HOSPITAL, SAINT JOHN:** On May 15 the Alumnae entertained the graduating class of 1929, at a dinner-dance and bridge in the Admiral Beatty Hotel.

On May 17, the graduating exercises were held in the Nurses Home. Col. Murray MacLaren, C.M.G., M.P., presented a picture to the Nurses Home of Jeanne Mance, founder of Hotel Dieu Hospital, Montreal. Addresses were given by Dr. MacLaren, His Lordship Bishop LeBlanc, Mayor W. W. White, president of the Training School; Mrs. R. N. B. Robertson, president of Women's Hospital Aid; County Warden McAllister, and Councillor G. H. Simpson.

Miss Jennie M. Stephenson received \$10 in gold for general efficiency, and the Alumnae prize for the best influence exerted during her three years' training was presented to Miss Viola M. McKeen.

The members of the graduating class are: Ruth Babb, Adelaide Cronkite, Edith Estey, Elsie Lawson, Viola McKeen, Mary Reed, Jennie Stephenson, Evelyn Black, Margaret Darling, Alberta Foster, Helen MacDorman, Hazel Myles, Gladys Scovil, Elva White.

The Hospital has been honoured in the appointment of Miss Margaret Murdoch as one of the four delegates who will represent the nurses of Canada on the Grand Council of the International Congress of Nurses, which meets this July in Montreal.

Miss Ella Cambridge is in Boston taking a special course in Massage and Electro-Therapy, after which she will visit in Toronto.

**ST. STEPHEN:** The May meeting of the St. Stephen Chapter of the New Brunswick Registered Nurses Association was held in the Chipman Memorial Hospital. After a short business meeting, a social time was spent guessing "Who's Who," each nurse presenting an old photograph of herself. After the contest and awarding of prizes refreshments were served.

The Private Duty Section of the Chapter held a business meeting on May 2nd. An official registry was organized, which will be located at the Chipman Memorial Hospital under the supervision of Miss Grace Moffit, superintendent.

**CHIPMAN MEMORIAL HOSPITAL, ST. STEPHEN:** The Alumnae gave a banquet to the graduating class of 1929, at which twenty-five were present. The tables were decorated with the hospital colours, and miniature Maypoles. After the banquet a social hour was spent renewing old acquaintances.

The graduation exercises of the class of 1929 took place on May 14. Following the invocation by Rev. E. Hailstone; the president, Mr. J. L. Haley, made a few opening remarks, outlining the progress made by the hospital during the past year. This was followed by a most interesting address to the graduates by Dr. E. V. Sullivan. After the presentation of the diplomas by Mr. A. A. Laffin, the Harold Richardson prize was presented to the Intermediate class by Mr. Haley. Miss Bessie Folster won the first prize of \$30.00, and Miss Alma Clarke the second of \$20.00. Following the exercises, the graduates and their friends were guests of the Board of Directors at a reception and dance.

Miss Gertrude Hughes is engaged in general duty at Laurentian Sanatorium, St. Agathe des Monts, P.Q., and Miss Alice McConnell, in similar work at the Tuberculosis Sanatorium at Presque Isle, Maine.

Miss Nellie Spinney has resigned from the staff of Community Hospital, Fort Fairfield, Maine, and will spend the summer with her mother in St. Stephen.

### NOVA SCOTIA

Miss Marjorie Trefry has been relieved as Industrial Nurse at Moirs Limited, Halifax City, by Miss Gertrude Crosby. Miss Marjorie Trefry has taken a post on the Dalhousie Health Clinic Nursing Staff.

Miss Helen Frances Oickle of South Milford, N.S., has been appointed Night Nurse at the Soldiers' Memorial Hospital, Middleton, N.S. Miss Oickle is a graduate of the New England Sanatorium and Hospital, Melrose, Mass.

### ONTARIO

Paid-up Subscriptions to "THE CANADIAN NURSE" for Ontario in June, 1929, were 1,162. Twenty-nine more than previous month.

#### APPOINTMENTS

Miss Mary Battle (St. Joseph's Hospital, Hamilton, 1928), as Day Supervisor of the Maternity Ward at Casa Maria, St. Joseph's Hospital, Hamilton.

Misses Phyllis Clark (Grace Hospital, Toronto, 1927) and Bernice Million (1928), to the nursing staff at the East General Hospital, Toronto.

Miss Hazel MacInnes (Wellesley Hospital, Toronto, 1917), as supervisor of the Obstetrical Ward, Royal Inland Hospital, Kamloops, B.C.

#### DISTRICT 2

**BRANTFORD:** Members of the Florence Nightingale Association were hostesses to the Alumnae at the nurses' residence, at a bridge.

The May meeting of the Alumnae was held in the nurses' residence. After a lengthy business session, Miss J. Davidson gave an interesting report of the Kingston meeting of the R.N.A.O. At the close, refreshments were served, during which Miss Jones rendered a solo.

**GENERAL HOSPITAL, GUELPH:** The annual graduation exercises took place on May 9th, at which fourteen nurses received their diplomas. Congratulatory addresses were delivered by Dr. Robert Harcourt, chairman, Dr. Angus MacKinnon, Guelph's oldest surgeon, and Mr. Edward Johnson, world-famous tenor. A reception was held later at the nurses' residence.

The annual dinner given by the Alumnae to the graduating class was held at Wyndham Inn, May 3rd. Toasts, a musical programme, and dancing brought a pleasant evening to a close.

Previous to sailing May 17th on the liner "Montrose," Miss N. J. Cooke, assistant superintendent, whose marriage to Dr. David Whaeley, formerly of Toronto, is to take place in Holland, was the guest of honour at many lovely showers, given by the nursing organizations and her friends. She was the recipient of a handsome tea service from the medical staff, a beautiful white gold wrist watch from the Board of Directors of the institution, and silver gifts from the nurses.

#### DISTRICT 4

**ST. JOSEPH'S HOSPITAL:** The Alumnae entertained the graduating class of 1929 at a dinner on May 23rd at Cottage Inn. Miss Elizabeth Quinn presided. Miss Regan, instructress, spoke to the class on the high standard of the profession, its variety and opportunity. Short speeches and toasts were given by Misses Helen Robinson, Moran, Coleman, Deitrich and Mrs. Wheatley. Miss Deitrich had come from Denver, Colorado, to be present at her sister's graduation. Vocal selections were rendered by Misses E. Melody and Jean Hanley.

Sister M. Monica has completed the Instructor's course at Toronto University.

Miss Mabel Clifford (1928) has accepted a position at Olean, N.Y.

Miss Norah Jardine (1924) has returned from the Canadian West, and is doing private duty nursing.

Miss Elizabeth Quinn (1920) has recovered from her recent illness.

#### DISTRICT 5

**WOMEN'S COLLEGE HOSPITAL, TORONTO:** The annual graduation and dance was held in Hygeia Hall on May 31st, the guests being received by Miss Meiklejohn and Mrs. Jones. The graduates were: Misses Grace Fletcher, Grace Clarke, Eva Wiltshire, Jessie Wagner, Lottie Blair, Dorothy MacGregor, Florence Smith, Elsie Perry, Annie Leung, Jean Pyper.

The alumnae entertained the graduating class at dinner at the King Edward Hotel. Miss Meiklejohn in her address stated that the hospital intended to establish a health clinic and free medical examination for poor



women of the city; also that they hoped to institute a post-graduate course in obstetrics. There is no such course in Canada at present. Miss Elsie Perry gave the class history, and Mrs. B. M. Aikens toasted the absent members.

**GRANT MACDONALD TRAINING SCHOOL FOR NURSES:** On the 9th of May the University Extension Department entertained at tea for the graduates of the new course in Hospital Instruction and Administration, at the Women's Union. The guests were received by Miss Emory, assistant directress of Public Health Nursing, Miss Pines, president of the graduating class, and Mrs. Dunlop.

The graduating students received words of congratulation and encouragement, particularly from those members of the profession who have been anxious to have the course started in Toronto. The need for nurses prepared for this special work has long been felt in the Training Schools for Nurses in Ontario, and the graduation of the first students is indeed a time of rejoicing for those interested in the advance of nursing education.

A great deal of the success of this first year is due to the efforts of Miss Gladys Hiscock, the supervisor of the course. The social event, which marked the end of the term, would have been complete in happiness had her presence not been denied. She has been seriously ill since the Easter recess.

The Alumnae gave a dinner to the graduating class on April 8th, followed by a theatre party.

The Junior Class entertained the graduating class at a dance on April 19th.

The Alumnae held a meeting on April 29th, at which it was decided to hold a monthly meeting on the last Monday of every month. A very interesting talk was given by Miss Pines, of New Zealand, on Dr. Truby King's method of Child Welfare.

**GRACE HOSPITAL, TORONTO:** The Alumnae entertained the graduating class at their Annual Dance on April 18th at the Parkdale Canoe Club.

An impromptu reunion was held in March at the Hospital of the class of 1905. Of the nine members eight are still living, and seven were present on that occasion, and to the great pleasure of all, Mrs. C. J. Currie (Miss Elizabeth M. Parton, Montreal General Hospital), who was superintendent of the Hospital from 1901 to 1908, was also present.

Letters have been received from Miss Hilda Duckworth (1927) from Duzdab, Persia, where she is engaged in missionary work.

#### DISTRICT 8

Some thirty-eight nurses of the Public Health Section of the District recently attended a dinner held at the Chelsea Club, Ottawa. During the evening short addresses were given by Miss Elizabeth Smellie, chairman of the National Public Health Section, and Miss Ethel Cryderman, chairman of the Public Health Section, R.N.A.O. A representative from each group of workers

present conveyed greetings and told something of the work she was doing in Ottawa.

**CIVIC HOSPITAL, OTTAWA:** The class of 1930 entertained the graduating class at dinner at the Chateau Laurier. The following toasts were proposed: "The King," by Miss B. O. MacInnes; "The Graduate Staff," Miss M. McDiarmid, with Miss Jenkins responding; "The Graduating Class," by Miss B. O. MacInnes, responded to by Miss Frizell; "The Training School Office," by Miss M. Norman, responded to by Miss Gertrude Bennett; "The Doctors," by Miss I. MacDowell.

The commencement exercises of the School of Nursing were held on May 22nd. The principal speaker was Dr. J. J. Heagerty, of the Department of Pensions and National Health, who addressed them on the development of the nursing profession in Canada since the establishment of the first hospital in Quebec in 1639. Dr. D. M. Finnie, chairman of the Board of Trustees of the Hospital, who presided, was assisted in the presentation of diplomas and pins by Miss Gertrude Bennett and Miss Marion May. The congratulations and greetings of the medical staff were conveyed by Dr. J. Fenton Argue.

Miss Anne Burns, in charge of the Physiotherapy Department, has returned to duty after spending the winter in Florida.

**GENERAL HOSPITAL, OTTAWA:** Twenty-five nurses received their diplomas at the graduation exercises held on June 6th. On this occasion it was announced that in future the Training School of the Ottawa General Hospital would be affiliated with Ottawa University. Addresses were made by Father Robert, Dr. F. P. Quinn and Dr. J. H. Lapointe. Miss Kathleen Healey, of Ottawa, was awarded the first prize for general proficiency, while Miss Therese Charlebois obtained the highest standing in general theory; Miss Ida Gleeson the second prize for general proficiency and Miss Antoinette Despaties the second prize for excellence; Miss Veronique Gravel, of Ottawa, the prize for professional technique, and Miss Dorothy Knox, of Ottawa, the nurses' kit given by the Alumnae for practical nursing.

The work of the Cottage Hospital, in Pembroke, is being further extended by the addition of a medical laboratory which is now being installed. The purchasing and establishment of this new department is due to the generosity of the late Mrs. Alex. Jamieson.

The intermediate class entertained the graduating class at tea recently in the new Nurses Residence.

The Alumnae held a successful tea recently, the proceeds of which will be devoted to the I.C.N. Fund.

#### DISTRICT 10

On April 27th, District 10, of the R.N.A.O. entertained the superintendents and the graduating classes of the three headquarters hospitals: The McKellar-General, of Fort William; St. Joseph's, and the Port Arthur



Railway, Marine and General, at a banquet at the Royal Edward Hotel, in Fort William. Miss Jane Hogarth, president of the District presided. Toasts and speeches were followed by a vocal and instrumental programme.

The May meeting was held on May 2nd, at St. Joseph's Hospital, Port Arthur, with Miss Jane Hogarth in the chair. Mr A. F. Hansuld gave an address on "Mental Attitude," followed by an interesting paper by Dr. T. H. Hutchison on "Oral Infection in relation to Systemic Disease." Miss Lovelace, secretary, presented her report of the Convention of the R.N.A.O., held in Kingston on April 4, 5 and 6.

MCKELLAR-GENERAL HOSPITAL, FORT WILLIAM: On May 14th, the graduating exercises took place of the nurses of the 1929 class of the hospital. Miss Dorothea Spence gave the valedictory address, and prizes were given to: Miss Doris Smith, gold medal; Miss Reta McCleod, silver medal. The graduates were: Misses Louise Ellen McGogy, Dorothy Mary Burton, Kathleen Oliver, Ada Helen King, Muriel Irene Boisseau, Myrtle Reany, Oda Clarina Dorothea Spence, Nellie Cullen, Sadie Mayne Dodge, Edith Florence Muir, Mary Margaret Pyne, Doris Smith, Reta Kathryn McCleod, Catherine Hope Mackintosh.

The following evening the Board of Trustees were hosts to the graduating class at a brilliant dance and supper at the Royal Edward Hotel.

The Alumnae entertained the graduates of 1929 at a theatre party, followed by supper at the Royal Edward Hotel.

RAILWAY, MARINE AND GENERAL HOSPITAL, PORT ARTHUR: The graduation exercises of the 1929 class were held in St. Paul's Church, on May 16th, when the following graduates received their diplomas: Misses Lulu Hutchinson, Daisy Wear, Jean Heron. Prizes were presented to: Miss Jean Heron, General Proficiency, Dentistry, and prize for highest marks in Medicine; Miss Daisy Wear, Obstetrics; Miss Lulu Hutchinson, Obstetrics, and Records and Charting.

A reception was held later in honour of the graduating class.

## QUEBEC

GENERAL HOSPITAL, MONTREAL: The Alumnae entertained the graduating class at a dinner on May 28th, at the Ritz Carlton Hotel, at which the guest of honour, Dr. Helen R. Y. Reid, chairman of the Advisory Board, The School of Graduate Nurses, McGill University, gave an inspiring address.

The graduating exercises took place on May 30th, when Dr. C.K.P. Henry gave the main address on the practice of their profession. Prize winners were as follows: general proficiency, Miss Grace K. Reinauer, of Munich, Germany, and Miss Anna M. Mackay, of Cochrane, Ont., the Mildred Hope Forbes prize for the highest aggregate

marks during the three years' course, Miss Glenna M. Hawley, of Ormstown, P.Q., and Miss Grace A. Perry, of Barston, P.Q. special prize for general proficiency, Miss Jean M. Dunlop, of Colchester County, N.B., special prize for general application during the three years, Miss Elli M. Henriksson, of Myllykoski, Finland; the Mildred Hope Forbes scholarship for McGill University, Miss Mary J. Denniston, of County Longford, Ireland.

Miss Anne Cromwell has resigned her position as charge nurse of Ward "L," and has accepted a position as Operating Room Supervisor at the Regina General Hospital.

Miss J. C. Murphy, who has been travelling in the United States for the past three months under the Rockefeller Foundation in connection with public health has resumed her duties in the Out-Patient Department.

The engagement of Miss Freda Cromwell (1926), to Mr. Redington Moore, of Easton, Penn., is announced.

The sympathy of the members is extended to: Misses Read, in the loss of their mother; Miss G. MacConachie, her mother; Miss Caldwell, her brother.

Scholarships to McGill University have been awarded to Miss Clarice Barraclough, of the V.O.N., in Public Health; Misses Marie Des Barres and Blanc Herman, of the nursing staff, in administration.

SCHOOL FOR GRADUATE NURSES, MCGILL UNIVERSITY, MONTREAL: The announcement has been made of the graduation of the whole class of twenty-four, seventeen of whom obtained first class general standing. Following is a list of the graduates: Certificates in Public Health Nursing: Mary Seabury Mathewson, Montreal, P.Q. (first class); Katherine Hanington Covert, Dartmouth, N.S. (first class); Vera Beronia Allen, Toronto, Ont. (first class); Madeline Stuart Taylor, Montreal, P.Q. (first class); Frances Marguerite Folkins, Montreal, P.Q. (first class); Anna Maria Frances MacFarland, Montreal, P.Q. (second class); Mabel Gladys Black, Montreal, P.Q. (third class).

Certificate in Administration in Schools of Nursing: Marion Sarah Myers, Guysboro, N.S. (first class); Vernie Louise Kerr, Montreal, P.Q. (first class); Ida McAfee, Paisley, Ont. (first class); Kathleen Burbidge Hill, St. Stephen, N.B. (first class); Mary Irene McQuade, St. John, N.B. (first class); Stella Orr, Kensington, P.E.I. (second class); Ethel Clark, Montreal, P.Q. (third class).

Certificate in Training in Schools of Nursing: Anna Gertrude Brown, Paisley, Ont. (first class); Hazel Keirstead, St. John, N.B. (first class); Ursula Whitehead, Victoria, B.C. (first class); Jessie Gordon, Electric, Ont. (second class); Martha Rose Racey, Winnipeg, Man. (third class); Catherine Willard Mills, Ormstown, P.Q. (third class).

Diploma in Nursing Education: Mabel Irene Cunningham, Peterborough, Ont. (first class); Eileen Flanagan, Montreal, P.Q.

(first class); Mary Agnes Turner, Almonte, Ont. (first class); Elizabeth Moseley, Red Deer, Alta. (first class).

**Medals and Prizes:** The Lieutenant-Governor's Silver Medal for the highest standing in the course in Training in Schools of Nursing (diploma course), Mabel Irene Cunningham; The Lieutenant-Governor's bronze medal for the highest standing in the course in Public Health Nursing, Mary Seabury Mathewson; Dr. Helen R. Y. Reid's prize for the highest standing in Administration in Schools of Nursing, Marion Sarah Myers.

**CHILDRENS MEMORIAL HOSPITAL, MONTREAL:** Miss W. Kirby (1926), is doing relief work at the hospital during the summer months.

**ROYAL VICTORIA HOSPITAL, MONTREAL:** Miss Rita Ackhurst (1924), has resigned from the operating room staff and has left for Providence, Rhode Island. Miss Cowie (1928), has succeeded her.

Miss Marguerite Bellhouse, for many years in charge of the Eye, Ear, Nose and Throat Department has resigned and has accepted a position in the Admitting Office of the Hospital.

Miss Augustine Rainboth (1920), has joined the staff at Ste. Anne's Military Hospital, Ste. Anne's, Quebec.

Miss Mary Roach (1927), is doing special nursing in New York.

Miss Anne Slattery (1920), has resigned from the school for Graduate Nurses, McGill University, and is taking a year's rest.

Miss Milla MacLellan (1915), and Miss Alice Goff (1926), have received appointments from the C.N.R., and are at Jasper Park Lodge for the summer.

Miss Stella Byrne (1925), has resigned from Cornerbrook Hospital, and has accepted a position in the Anaesthetic Department at Johns Hopkins Hospital, Baltimore.

**JEFFERY HALE'S HOSPITAL, QUEBEC:** The Alumnae gave their annual dinner at the Chateau Frontenac on Tuesday, May 14th, the guests of honour being the members of the graduating class: the Misses Lorna Weatherbie, Bertha Mahan, Gladys Weary, Ina Allison, Nora Martin, Ina West, Margaret Noonan, Lillah Trenaman and Eleanor Scott.

On May 15th, in the McKenzie Memorial Wing, diplomas were presented to the graduating nurses, followed by a concert. Refreshments were served by the nurses and a reception held.

On May 16th, the graduation dance was held, under the direction of Miss C. E. Armour and Miss Ina West.

Miss Frances Simms (1925), who spent the winter in the old country, has returned to Quebec, and is again doing private duty nursing.

Miss Marjorie Semple (1927), who has been living in Muskogee, Okla., for the last year has returned home.

Miss Cecile Caron (1917), has accepted a position with Dr. Hubbard as office nurse.

Miss Lorna Weatherbie (1929), has been appointed to the staff to fill the vacancy made by the resignation of Miss Nicol.

Mrs. S. Barrow, honorary president of the Alumnae who spent the winter abroad has again returned home.

The annual Pound Day was held in the Hospital on May 14th, and it proved most successful.

Miss Doris M. Jack (1923), who spent the winter in Victoria, B.C., has returned to Quebec and resumed her position as nurse in charge of the Quebec Immigration Detention Hospital.

## VICTORIAN ORDER OF NURSES

At the annual meeting of the Victorian Order of Nurses for Canada, held in Ottawa on May 8th, sixteen nurses were registered. At this meeting, 42 of the Order's 71 districts had representation.

### APPOINTMENTS

Miss Eileen Wright (Winnipeg General Hospital), to the staff in Saskatoon.

Miss Madeline Taylor (Montreal General Hospital), to open the new district in Regina. Miss Lillian Edmison (Nicholl's Hospital), in charge of the District of Cobalt.

Miss Dorothy Milks to the staff in Sarnia.

Miss Viola McFaul has been transferred to St. Catharine's.

Miss Jessie Surrell has been transferred to Timmins.

Miss Claire Rochez (Ottawa General Hospital), to the staff at Lachine, to fill the vacancy occasioned by the resignation of Miss Elodie St George.

### RESIGNATIONS

Miss Eileen Graham from the staff of the Victoria Hospital in Renfrew.

## C.A.M.N.S.

**MONTREAL, P.Q.:** At the annual dinner of No 3, Canadian General Hospital (McGill), held in the University Club, on May 6th, the fourteenth anniversary of the sailing of the unit for Overseas Service, the Nursing Sisters were the guests of their former O.C., Brig. Gen. H. S. Birkett.

Twenty-five of the original Sisters were present. After the toasts, a very enjoyable hour was then spent by former officers and sisters, during which an autographed copy of the history of the Unit was presented to Dr. R. C. Fetherstonhaugh, the author.

**WINNIPEG, MAN.:** The Nursing Sisters Club, of Winnipeg, and friends met at an enjoyable tea in the Marlborough Hotel on May 11th. The guests were received by Miss M. McGilvray and Miss K. M. McLearn.

The Nursing Sisters were represented among other organisations at the annual memorial service held at the "Next of Kin" monument on May 19th, and in the afternoon of the same day several took part in the Decoration Day services.

## BIRTHS

- BICKNELL**—On May 12, 1929, at Lindsay, Ont., to Mr. and Mrs. A. C. Bicknell (Clara V. Hutchinson, Grace Hospital, Toronto, 1923), a son.
- CHOATE**—Recently, at Calgary, Alta., to Mr. and Mrs. C. A. Choate (S. Lunn, Calgary General Hospital), a son.
- COCKBURN**—On February 6, 1929, at Toronto, to Mr. and Mrs. William Cockburn (Claire Louise Tilt, Grace Hospital, 1920), a son (Donald William) and a daughter (Anne Claire).
- CONWAY**—On February 24, 1929, to Dr. and Mrs. Conway (Abigail Derbyshire, Wellesley Hospital, Toronto, 1921), a daughter.
- GEORGE**—On May 19, 1929, at London, Ont., to Mr. and Mrs. Walter G. George (Velma C. Meadows, Galt General Hospital, 1925), a son (Floyd Joseph).
- GRANGER**—On May 20, 1929, at Vancouver, to Mr. and Mrs. John Granger (Freda Martin, Vancouver General Hospital), a son.
- HUTCHISON**—On May 27, 1929, at Montreal, to Dr. and Mrs. Keith Hutchison (Melicent Branch, Royal Victoria Hospital, 1924), a son.
- MITCHELL**—On May 17, at Saint John, N.B., to Mr. and Mrs. J. J. Mitchell (Frances O'Keefe, General Public Hospital, Saint John), a daughter.
- MACDONALD**—On December 29, 1928, at Toronto, to Dr. and Mrs. John MacDonald (Miriam Smith, Wellesley Hospital, Toronto, 1923), a son.
- MCDONALD**—In August, 1928, to Mr. and Mrs. Leonard McDonald (Miriam Davis, Wellesley Hospital, Toronto, 1919), a son.
- O'SHAUGHNESSY**—On May 13, 1929, at Montreal, to Dr. and Mrs. P. E. O'Shaughnessy (Audley Fraser, Montreal General Hospital, 1924), a son.
- POWER**—On February 2, 1929, at Toronto, to Mr. and Mrs. Fred Power (Olive Mary Noble, Grace Hospital, 1921), a son (Frederick Joseph).
- RAMSEY**—On June 2, 1929, at Montreal, to Dr. and Mrs. Stuart Ramsey (Juliette Pelletier, Montreal General Hospital, 1914), a daughter.
- REDDY**—On May 27, 1929, at Montreal, to Mr. and Mrs. Eric Reddy (Agnes Bigelow, Royal Victoria Hospital, 1925), a daughter.
- RUNDLE**—On May 29, 1929, at Oshawa, Ont., to Dr. and Mrs. F. J. Rundle (Mabel Hutchinson, Wellesley Hospital, Toronto, 1918), a son.
- RUSH**—On December 5, 1928, at Toronto, to Dr. and Mrs. J. W. Rush (Reita Book, Wellesley Hospital, Toronto 1920), a daughter.
- TOMPSETT**—On May 12, 1929, to Dr. and Mrs. David Tompsett (Leila McGinnis, Vancouver General Hospital), a son.

**TRAINOR**—On May 6, 1929, at Saint John, N.B., to Mr. and Mrs. J. Clifford Trainor (Ada Foley, General Public Hospital, Saint John), a son.

**WILSON**—On May 12, 1929, at Montreal, to Mr. and Mrs. Wilson (Eva Farrell, Montreal General Hospital, 1917), a daughter.

## MARRIAGES

- BAGLOW**—**WATSON**—On May 4, 1929, at Toronto, Marjorie Blanche Watson (Grace Hospital, Toronto, 1925), to John Baglow. At home, Flushing, N.Y.
- DUKE**—**O'HEIR**—On April 3, 1929, at Caledonia, Ont., Margaret O'Heir (St. Joseph's Hospital, Hamilton), to Alphonsus Duke.
- FERGUSON**—**WALTERS**—In February, 1929, Doris Walters (Wellesley Hospital, 1928), to James Ferguson, Weston, Ontario.
- FISHER**—**REED**—On May 22, 1929, Frances L. Reed (Montreal General Hospital, 1912), to Rev. Lawrence H. Fisher, of Winnipeg.
- GEDDES**—**TERRY**—On January 28, 1929, Beatrice Terry (Wellesley Hospital, 1925), to Rt. Rev. W. A. Geddes, Bishop of Mackenzie River.
- GORDON**—**TIMMINS**—On June 4, 1929, at Vancouver, B.C., Laura B. Timmins (Vancouver General Hospital, 1922), to Ray Gordon.
- HALL**—**MACWATT**—On March 21, 1929, at Rockingham, N.S., Esther MacDonald MacWatt to James Hall. At home, Halifax, N.S.
- HARPER**—**WRAY**—On May 23, 1929, at Vancouver, B.C., Florence Wray (Vancouver General Hospital, 1927), to William Harper.
- HIGGINS**—**BOYES**—On April 1, 1929, at Hamilton, Genevieve Boyes (St. Joseph's Hospital, Hamilton, 1917), to Charles Higgins.
- KENNEDY**—**GIBBARD**—On May 10, 1929, at Vancouver, B.C., Louise Gibbard (Vancouver General Hospital, 1926), to William Kennedy.
- LACEY**—**HARDING**—On June 8, 1929, at Chateaugay, P.Q., Louise Harding (Children's Memorial Hospital, 1927), to Edward Lacey, of Grand Falls, Nfld. At home, Bishops Mills, Ont.
- MORGAN**—**DEGEAR**—On June 1, 1929, at Vancouver, B.C., Ruth DeGear (Vancouver General Hospital, 1929), to Robert Morgan.
- McKENZIE**—**CAIRNS**—On June 5, 1929, at Vancouver, B.C., Lulu Cairns (Vancouver General Hospital, 1927) to Alister McKenzie.
- PARSONS**—**SEVENPIFER**—On June 5, at Jarvis, Ont., Violet L. Sevenpifer, of Hamilton (Hamilton General Hospital, 1927), to C. A. Parsons, of River Rouge, Mich.

**GISBORNE—STEVENSON**—On June 8, at Wakefield, Quebec, Marian Ruth Stevenson (Lady Stanley Institute), to Lionel Reginald Gisborne, of Ottawa.

**MURPHY—THOMAS**—On April 2, 1929, at St. Stephen, N.B., Jeanette Thomas (Chipman Memorial Hospital, 1926), to Albert Murphy, of Yonkers, N.Y.

**PIGOTT—JACKSON**—On April 23, 1929, at Hamilton, Evelyn Jackson (St. Joseph's Hospital, Hamilton, 1927), to Roy Pigott.

**PIKAART—CAMPBELL**—On April 6, 1929, Beryl Ellehae Campbell (Montreal General Hospital, 1928), to Russell Den Ouden Pikaart of Belleville, N.Y.

**SCOTT—MILLER**—In February, 1929, Avis Miller (Wellesley Hospital, 1926), to Edward Scott, Toronto.

**SMITH—FURNISS**—In December, 1928, Harriet Furniss (Wellesley Hospital, 1922), to Murray Smith.

#### DEATHS

**JEFFERSON**—Suddenly, on June 4, 1929, at Ottawa, Mrs. R. Jefferson (Edith Beatrice Strong, Lady Stanley Institute Training School for Nurses, Ottawa, 1907).

**POMEROY**—On June 6, 1929, at New York, of spinal meningitis, Ruth Pomeroy (Royal Victoria Hospital, 1920), beloved daughter of Major and Mrs. Pomeroy, Compton, Quebec.

#### BOOK REVIEWS

In the Nursing Education Department there is published an interesting article, "Methods in Teaching Nursing Ethics," by Charlotte Talley, author of "Ethics—A Textbook for Nurses," which in its second edition contains Lesson Plans and makes an application of ethical principles to nursing problems. Published by G. P. Putnam & Sons, New York City.

**Books Received:** "Ethics and the Art of Conduct for Nurses," by Edward F. Garesche, S.J., M.A., LL.B.; three hundred and forty-one pages; price, \$2.50. Published, 1929, by W. B. Saunders Company, London and Philadelphia. Canadian agents: McAlinsh & Co., Limited.

#### Graduation—(Continued from page 356)

1. Administer your aid with a spirit of devotion and assurance. Know your work, and let the patient and his friends know that you know, and all without ostentation.

2. Accuracy, punctuality, honesty, and dignity are smooth waters for your voyage, but the cross-currents of snobbery must be avoided.

3. Never be reticent in asking advice, and never be above taking it. None of us know all there is to know. Some of us need to know what others already know.

4. Diligence, efficiency, sincerity and tact constitute a never-shifting ballast, a necessity in running a true course. Slothfulness and incompatibility are barnacles on the keel.

5. Cultivate affability, temperance, veracity and thrift. Extravagance and debt are notoriously prevalent in the profession. Pay as you go. If you can't pay, don't go.

6. Integrity, patience, long-suffering, and a studied silence are assisting trade winds, but the querulous gossip and the talker of scandal have caused more wrecks than all the nor'easters that ever blew.

7. If you would be popular, be sparing of other people's strength, make yourself at home and wait upon yourself, and when your term of duty is ended, leave them with a smile, riding the crest of the wave.

And so, on our mortal journey,  
We dream as the years glide by,  
And our lives resemble a river  
That reflects the high swung sky.  
To some the reflection is murky,  
To others, the colour is blue,  
Let us all sail under pure colours,  
In a ship that will carry us through.

#### THE CANADIAN NURSE

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The Frontier Nursing Service has positions for Public Health Nurses certified under a British Central Midwives' Board. Because of waiting list, applications must be received several months in advance. For further particulars, address the Director, Mrs. Mary Breckinridge, Wendover, Leslie County, Kentucky.

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## AUGUST, 1929

MEDICAL ASPECTS OF IMMIGRATION	- - - - -	<i>Dr. J. D. Page</i>	395
THE FUTURE OF MENTAL NURSING	- - - - -		399
EDITORIALS	- - - - -		401
THE VENEREAL DISEASE CLINIC	- - - - -	<i>Dr. Gordon Bates</i>	402
NERVOUS TROUBLES OF CHILDREN	- - - - -		407
POLIOMYELITIS	- - - - -		408
DIET IN DISEASE	- - - - -	<i>E. Laura Cody, B.H.Sc.</i>	411
DEPARTMENT OF NURSING EDUCATION:			
THE TEACHING OF BACTERIOLOGY	- - - - -	<i>Ruth F. Walden</i>	413
HOW FLORENCE NIGHTINGALE'S BIRTHDAY WAS KEPT IN CENTRAL CHINA	- - - - -	<i>Gladys Stephenson</i>	415
MISS JEAN BROWNE IN GENEVA	- - - - -		416
ANNOUNCEMENT	- - - - -		416
MISS E. KATHLEEN RUSSELL	- - - - -		417
BOOK REVIEW	- - - - -		417
DEPARTMENT OF PRIVATE DUTY NURSING:			
IMMUNOLOGY AND PROPHYLAXIS	- - - - -	<i>Dr. W. T. Shirreff</i>	418
DEPARTMENT OF PUBLIC HEALTH NURSING:			
MENTAL HEALTH IN THE SCHOOL	- - - - -	<i>E. de V. Clarke</i>	422
MENTAL HEALTH IN THE NURSERY SCHOOL	- - - - -	<i>Joyce Davidson</i>	425
PUBLIC HEALTH	- - - - -		427
NURSES BULLETIN	- - - - -		427
NEWS NOTES	- - - - -		428
VICTORIAN ORDER SUPERVISORS DEMONSTRATE TO MCGILL STUDENTS	- - - - -	<i>M. L. Moag</i>	433
OFFICIAL DIRECTORY	- - - - -		435



# Medical Aspects of Immigration

By J. D. PAGE, M.D.

I wish at the outset of my remarks to thank this Conference for affording me the opportunity to say a few words regarding the medical aspects of immigration, which has been one of the prime interests of the Federal Department of Health since its inception in 1919.

The Immigration Act of Canada, which became law and was put into force at the beginning of the fiscal year 1903, provides for the medical examination of immigrants arriving at our ocean ports. For this purpose immigration medical officers were appointed whose work consists in endeavouring to detect those persons who come within the following classes of "prohibited immigrants" as set out in the Immigration Act:

1. Idiots, imbeciles, epileptics, feeble-minded or insane persons.—Sec. 3 (a).

2. Persons affected with tuberculosis or other contagious or loathsome disease which is not curable within a reasonably short time.—Sec. 3 (b).

3. Immigrants who are dumb, blind, or otherwise physically defective to a degree rendering them liable to become a public charge.—Sec. 3 (c).

4. Persons of constitutional psychopathic inferiority.—Sec. 3 (k).

5. Persons with chronic alcoholism.—Sec. 3 (l).

6. Persons (other than those stated above) who are mentally or physically defective to such a degree as to affect their ability to earn a living.—Sec. 3 (m).

As we are now reaching the quarter of a century mark in the medical examination of candidates for Canadian citizenship, it seems fitting that the public should know something of what has been accomplished during the twenty-five year period in the matter of selection of the new-comers to

our shores, and of the protective steps which have been taken to prevent the influx of the mentally and physically unfit, in order that the standard of the Canadian people may not be lowered.

At the inception of this policy and for a few years following, while the total immigration at ocean ports had already reached the one hundred thousand mark per annum, at the important gateway of Canada, Quebec, through which port more than 75% of the immigration enters the country, this responsible work was entrusted to only two part-time medical officers who conducted these medical inspections as a side line of their general practice. This measure was manifestly inadequate.

The records show that for the first few years little attention was paid to anything else than to search among the foreign immigrants for the grave infectious eye disease known as Trachoma. In their hurry to have their ships reach Montreal with the least possible delay, the steamship companies frequently availed themselves of the privilege of landing immigrants at such late hours in the day as to make it quite impossible to conduct a satisfactory medical inspection, and it became apparent that a large number of medical inspectors was needed. Accordingly, in the summer of 1906, the staff was increased to six members and put under the authority of the medical superintendent of the Immigration Hospital, who became the chief medical officer of the port staff as well as that of the hospital. This augmented staff carried on until 1912, by which time it was again increased to eleven, still all part-time officers. But the conditions under which they were compelled to do their work continued to be so unfavourable that no better results were accomplished.

During the interruption of the flow of immigration caused by the great war, every opportunity was taken to

(Paper read by Dr. Page, Chief of the Immigration Medical Division, Federal Department of Health, before the Canadian Conference on Social Work, April 25, 1928.)

make representations to the authorities at Ottawa to demonstrate the necessity of having full-time men appointed to the service, in the light of the glaring evidence that men who had to depend more upon the revenue derived from their general practice than upon the remuneration received from the Government could not have sufficient interest and give enough attention to the work to perform it as it should be.

The overdue advent of the new Federal Department of Health after the war facilitated the beginning of the reforms which such an inadequate system demanded. The activities of the Department of Health in this direction may be summarised as follows:

1. The establishment of suitable hours to carry out medical inspection.

2. The appointment of permanent full-time men through the Civil Service Commission.

3. Co-operation with the Immigration Department in order to have the Immigration Act so amended as to provide for the mandatory assessment of fines against steamship companies for bringing certain prohibited classes of immigrants.

4. Inducing the steamship companies to pay better salaries to their ships' medical officers, so as to make it worth while for them to remain in the service with a full consciousness of their responsibility and the necessity of their co-operating with the Canadian Medical Service in reporting to the latter any case found on board coming under the Immigration Act.

5. Holding conferences with ships' surgeons and officials of the steamship companies at Montreal from time to time in order to explain to all concerned the medical requirements of the Immigration Act.

6. The appointment in London, England, of a medical adviser to the Canadian Department of Immigration in that city, together with an assistant, who have since rendered splendid service.

7. The organisation of a roster of medical examiners in the British Isles

in conjunction with the other British overseas countries for the examination of their respective immigrants, under the supervision of the London medical adviser and his assistant.

8. Last, and perhaps most important of all, the establishment overseas, effective from February 15th, 1928, of a compulsory system of medical inspection of all prospective immigrants, prior to leaving their home, by Canadian Medical Officers of the Federal Department of Health.

For while Canada has a very good Immigration Law, after many years of endeavour to apply it at the wrong end, that is, at this side of the Atlantic, its results have been very disappointing.

As a result of the medical officer's certification, in compliance with the Immigration Act, immigrants who are found on arrival to be mentally defective, suffering from certain contagious diseases or affected with some serious physical defects, may be refused permission to land. I may here mention that their rejection or admission rests entirely with the civil examiners of the Department of Immigration. The medical officers of the Health Department have no executive functions; they merely advise the former Department as to the health of the individuals. As many of you know, from the necessarily cursory examination which takes place at the ports of landing, where the new-comers are passed through the inspection lines at the rate of some three hundred an hour, many defects are liable to escape the attention of the medical inspectors. The result is that many of those suffering from serious affections prohibited of entry under the law, have succeeded in slipping through and have later become public charges and eventually deported.

Such an outcome is a serious matter to the persons concerned; having given up home and employment in their native land, their re-establishment on return necessarily proves difficult. Prospective immigrants in recent years have been recommended, therefore, before taking active steps towards

migrating to this country, to present themselves for thorough medical examination to a doctor in their home district, selected from the roster approved by the Department of Health of Canada and already referred to. In the past, however, only in the case of unaccompanied women, children's immigration schemes, and Government-assisted passages to Canada, has such medical examination been compulsory. The results which such examination has produced are very marked. A comparison of the official figures shows that for 1926, the last complete period for which figures are available, out of approximately 95,000 immigrants arriving in Canada who did not undergo compulsory examination before embarkation, the medical line inspection at the ports of entry, which, as I have already stated, is not adequate for the detection of certain types of disease, eliminated only twenty-eight, or .03 per cent. of mental defectives and forty-one, or .04 per cent. under the head of loathsome and communicable dangerous diseases. On the other hand, of the 20,000 assisted immigrants who underwent compulsory examination before embarkation, one hundred and fifty, or .75 per cent. of the former group, and one hundred and ninety-five, or .97 per cent. of the latter group, were certified as unfit and prohibited from entry into Canada. All things being equal, there is no particular reason why the percentage should be lower in the one case than in the other.

Besides the haste with which the medical inspection is carried out at the time of arrival, and which accounts for so few being held, the mandatory assessment of a fine of \$200.00 is imposed on the shipping interests when they bring an insane or tuberculous person. Hence, the most visible defects are now being held back before embarkation by the companies' medical officers.

Either because the class of the misfits who are successful in evading detection before they embark, or as they land, has become more numerous, or as a

consequence of the increased activities of the municipalities in procuring their deportation, the latter reached unprecedented figures during the calendar year, 1927.

The surveys which have been made of many public institutions of the country during the last few years through the initiative of the National Committee for Mental Hygiene and the intensive study pursued by such social organisations have revealed the tremendous burden thrown upon the State by the inadequate system of medical inspection that has been too long maintained. Criticism from many quarters has been heard periodically, that our selective method was not all that could be desired. However, it was not until the last two or three years that this criticism assumed a constructive character and was formulated in a concrete manner.

This came as the result of discussion which had taken place at the regular sessions of the Dominion Council of Health, the Inter-provincial Conferences of the Prime Ministers held in Ottawa, and of several important social agencies as well, and impressed upon the Federal authorities the necessity of taking radical steps to meet the situation.

Following several conferences between both Immigration and Health Departments, at which the question was discussed exhaustively, the Government approved finally the policy under which every prospective immigrant to Canada shall be examined by a medical officer as to his or her mental and physical fitness before permission to emigrate to this country is granted. For this purpose it was decided to appoint a number of Canadian Medical examiners, and station them at key cities in Great Britain, Ireland, and on the continent of Europe. Under this policy, while admission to Canada would continue to be determined finally at the Canadian ports of arrival, no person would be permitted by our Department of Immigration to emigrate to this country until he or she had been examined and passed by an

officer of the Immigration Medical Service, Department of Health. A maximum degree of weeding out of the physically and mentally unfit would thereby be attained, thus reducing to a minimum the possibility of rejection on this side.

After the principle of overseas medical examination was approved and adopted by the Government, a conference was arranged in July, 1927, at Ottawa between the two Departments and the Montreal executive officers of the steamship companies. This conference was advised that it had been decided to replace the roster doctors by Canadian medical officers, who would examine not only prospective immigrants who were receiving financial aid from the Imperial or Canadian Governments, but all intending settlers in Canada.

In our tentative arrangements it was agreed to place our doctors in some ten strategic centres of the British Isles, such as Liverpool, Bristol, Birmingham, Glasgow, Aberdeen, Belfast, etc., also on the continent at the principal ports of departure, namely: Riga, Danzig, Bremen, Paris and Antwerp, on the understanding that if some of these doctors required extra assistance at certain times, due to congestion, the Department was prepared to provide same.

After an exchange of views and a full discussion, the steamship people declared themselves unanimously sympathetic to the scheme as outlined, and before we departed we felt that it would receive their whole-hearted co-operation.

The Canadian doctors went abroad in small groups and at intervals from the middle of October, 1927. . . . With the contingent of five additional medical officers who have sailed recently, making a total of twenty-seven in all, these will be placed in as many principal centres, from whence they will travel periodically to more than three hundred neighbouring towns on fixed dates, of which the intending immigrant will be kept informed by either the booking agent or the immigration officials.

In those isolated districts where immigrants could not report for examination and return home the same day, some forty-five roster doctors have been appointed to cope with the situation. . . .

The United States placed their Immigration Medical Inspectors in the British Isles and other European countries three years ago, and the result of their work has proved to be a decided success in every way. If Canada does not desire to be the dumping-ground of those would-be immigrants to this continent which the United States medical inspection system is weeding out, we must lose no time in keeping close guard at our own ports of entry by adopting the method which is working so successfully with our neighbours to the South.

It is beyond dispute that our system of examination of immigrants has been too lax. The Federal Government may under the Constitution be relieved from the responsibility of caring for our feeble-minded population, but it cannot refuse to accept responsibility for the admission of such people through our immigration ports of entry. At different times the National Committee for Mental Hygiene have published some eloquent figures concerning the very serious problem of mental defectiveness in relation to immigration. To be consistent with its policy and by reason of the faith that is in it, the executive of that Committee at a special meeting held recently in Montreal, passed the following resolution:

"The National Committee urges the Federal Government to continue a strict adherence to the provisions of the Immigration Act, and to oppose the admission to Canada of undesirables as provided for in subsections (a), (b) and (k), of section 3 of the Immigration Act."

It is becoming more evident every day that Canada has reached that stage in her evolution where her people must think in Canadian terms when considering national affairs. This fact did not escape the attention of Sir Robert Horne, who travelled through



Canada recently and was quoted by the press as having declared, in the course of an address to the Canadian Club at Vancouver, that "he believed the Dominion had a perfect right to decide upon the fitness and training of those who seek admission." I

believe that you will at once agree with these sentiments. If you agree also that in our national politics we must think in Canadian terms, my last word to you is that this applies particularly to the important matter of selective immigration.

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## *The Future of Mental Nursing*

At the annual meeting, 1929, of the Mental Hospitals Matrons' Association of England, H. Wolseley-Lewis, F.R.C.S., M.D., addressed the association on the future of mental nursing. Excerpts from this address, as published in "The Nursing Times," March 23rd, 1929, are published herewith:

"In the report of the Departmental Committee appointed by the Minister of Health to consider in what way the nursing service in mental hospitals might be improved, of which I was a member, we noted with satisfaction the formation of the Mental Hospitals Matrons' Association on the ground that 'it would provide means for a progressive attitude towards the nursing of mental illness.'

"Your association was formed nearly six years ago, and I would ask you, each one of you, what you have done to this end? The General Hospital Matrons' Association has long been recognised as a great power in the nursing world, and has had great influence on the status and training of the general nurse, and I am here to urge you to go and do likewise for the mental nurse. A great responsibility rests on you at the present time; your decisions, your influence, your guiding hand can give the mental nurse that position and that training which are her rightful heritage and are of such inestimable benefit to those who suffer from disorder of the mind; so much has been done and said for the nursing of the physically sick that the

more important question of mental nursing has been sadly overlooked.

"Let me invite you to reflect on the importance of mental nursing. In no form of disease, not even in the case of children, is the patient so entirely dependent on the nurse as in mental disease. The law recognises this when it deprives the patient of his civil rights and even sets limits to his personal liberty because he is unable to look after himself. Surely this in itself should be sufficient incentive to all who would call themselves mental nurses to do their utmost by developing their character and devoting themselves to their training to fit themselves for what is admittedly a difficult job. Many of you must be aware how unsuitable for the work many of your nurses have been in the past, and one shrinks from contemplating the immense mass of suffering and mental anguish that may have been caused by their ignorance and stupidity.

"It is fundamentally important to regard mental nursing not as a separate profession but as a branch of the nursing profession. For the attainment of success, the ideal experience is that of complete training in both general and mental nursing. What are you doing to encourage this? The Magna Charta of the nursing profession was the passing of the Nurses' Registration Act. It put nursing on the same basis as any other profession; it gave the nurse a legal status; it gave her self-government. Not with-

out a struggle mental nurses were included in that Act; not without a struggle they have been offered a position of equality with every other nurse. What use are they making of their opportunities? Are they trying to justify themselves? Are they showing the grit and ability necessary to qualify for the place in the nursing world which is open to them? How many of them insist on going in for the General Nursing Council's examination? How many nurses have we in our mental hospitals who are doubly qualified? I am afraid to say how few!

"Who is responsible for this state of affairs? Surely your Association should have some power. You are the leaders of the profession. You meet here to discuss what is best for the mental nurse. You should frame a policy for the future, and insist on its being carried out. It is for you to demand that your nurses should attain a certain standard and should have a proper training. Some of you would appear to feel that you would place yourselves in opposition to your medical superintendents, but surely this is not so. You are both desirous of doing everything that is possible for the good of your patients, and while it is entirely right that the medical superintendent should have paramount authority, surely no superintendent would be so foolish as to arrogate to himself the management of a department in which he has had no training and of which he has not the detailed supervision. The nurse is the natural ally of the doctor, and they should look to each other for mutual

help in furthering the welfare of their patients.

"May I say, without offence, that the standard that you have demanded of your nurses in the past has not been high enough? You will say that you have difficulty in getting any sort of staff, leave alone those of a standard such as I suggest. The secret is that the higher the standard the easier you will find it to get the nurses. It is necessary to explain to the newcomer that nursing is a vocation, a chance for social service, and that her profession is something to be proud of. It is necessary to explain that she is being given a training without monetary payment for it, and that if she takes the opportunities offered her, and takes her double training, the ultimate gain justifies the immediate difficulties, as a much wider field of promotion is open to her, especially at the present time. I think a time may come when all those seeking the higher posts in the nursing profession will be required to have had some training in mental work, as no other experience can in the same way give her the knowledge that she is dealing not merely with a case but with an individual.

"Yours is the great profession; the State has granted you recognition: and while this brings with it advantages, it also brings responsibilities. Development and discipline must come from within. Responsibility especially rests with you at the present time, the future of mental nursing is in your hands and you will assuredly be called upon to give an account of your stewardship."

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## Editorials

### JOINT STUDY COMMITTEE ANNOUNCEMENT

Since June, 1927, the members of the Joint Study Committee of the Canadian Medical Association and the Canadian Nurses Association have been busily at work, laying the foundation for a survey of nursing education in Canada. Now the announcement is made by the secretary of the committee that the services of Dr. George Weir, Professor of Education, University of British Columbia, have been secured to conduct the survey. Dr. Weir will commence work on a full-time basis on November 1st, 1929.

The members of the committee feel that they have been specially fortunate in obtaining Dr. Weir's consent, and the consent of his university, to undertake this work. The Department of Education in the University of British Columbia is known to be outstanding in Canada, and Dr. Weir, although still a young man, has already had a brilliant career in the educational world. He is one of the few people in Canada who has had experience in conducting an educational survey. His success in connection with the survey of education in British Columbia is very well known.

The utmost co-operation of all Canadian Nurses will be needed when the survey is under way, in order to make it as effective as possible.

### MISS A. J. HARTLEY HONOURED BY DISTINGUISHED DECORATION

Miss Anne Hartley, R.R.C., Matron-in-Chief of the hospitals of the Department of Pensions and National Health, was awarded the Florence Nightingale Medal in May, 1929. This medal is awarded biennially by the International Committee of the Red Cross to a few nurses in different countries who have rendered conspicuous service in time of war or



public calamity. Miss Hartley is a graduate of the Toronto General Hospital and served overseas in France, Salonika and England from 1915 to 1919. She received the Royal Red Cross in 1916, and bar to this decoration in 1919. Since the war she has been matron of various government hospitals for returned soldiers and in January, 1929, was appointed Matron-in-Chief for the Hospitals of the Department of Pensions and National Health.

Only one other Canadian nurse has been awarded the Florence Nightingale Medal. That is Miss MacDonald, former Matron-in-Chief of the C.A.M.C. Nursing Forces, so that it is a matter of gratification to Canadian nurses that Miss Anne Hartley has been honoured by such a distinguished decoration.

## *The Venereal Disease Clinic*

By Dr. GORDON BATES, National Director, Canadian Social Hygiene Council

The problem of venereal disease control is extremely difficult. It seems to me that more information as to the possibility of ultimately reducing the problem may be obtained in a venereal disease clinic than anywhere else. We now have a large number of such clinics and our opportunity is multiplied proportionately. I desire in this paper to take up some of the questions which seem to be worthy of discussion at this time, and to make them intelligible to an audience whose desire is to contribute something to the mitigation of an evil which, having its origin in the misdirection of a force which normally adds immensely to the sum total of human happiness, through this misdirection instead adds disabilities and misery untold to the ward's problems; for the story of venereal disease and its results is a terrible and a tragic story indeed.

As far as is possible I am anxious to speak from the point of view of a clinic director, and to add something to what you have already heard this afternoon as to the elucidation of the problem as it unfolds itself through daily contact with the clinic patient.

Perhaps the first thing which strikes one in a large venereal disease clinic is that the patients on the whole seem very like patients attending the other clinics in the hospital, neither better looking nor worse looking either as to mental or physical characteristics. While it is true that there are certain characteristic outward signs in the early stages, most cases attending clinics are in a stage of the disease in which the average person could not detect the presence of the disease. This gives me the opportunity of emphasising the fact that there are large numbers of syphilitics who, despite the fact that they are harbouring germs which will ultimately

fulfil their sinister purpose and cause serious disability or death after long periods, are absolutely free of symptoms. Indeed many syphilitics have no idea of the fact that they have syphilis at all. This brings out the first point that I would make, that in all general hospitals all patients should be submitted to the routine Wassermann examination. One will find that perhaps 35% of cases discovered will be unaware of the existence of their infection. May I in passing remark that since the initiation of the anti-venereal disease campaign, we have discovered by means of the routine Wassermann that the percentage of syphilitics in the wards of Toronto General Hospital has been reduced from 12.8 in 1917 to 3.8 in 1927. From the beginning a large proportion of the cases attending the venereal disease clinic have been recruited from the wards by the continuous use of the routine Wassermann.

Syphilis from the hospital angle presents other problems. It is necessary to get patients, to keep patients once they have reported for treatment, to bring in sources and contacts; and all of these matters require special attention, besides the mere matter of seeing that patients receive efficient treatment, that they are properly educated in the danger of their disease to themselves and others, and that they are not discharged from treatment too soon.

I would emphasise the fact that the venereal disease clinic by itself will not control venereal disease. The control of venereal disease in any community depends on a study of the factors making for its existence, a recognition of the fact that these factors are social, and an attempt to deal with them on a community scale by community organisation.

Perhaps the first thing to be considered is education. In Toronto we



have had a persistent educational campaign from the beginning. The mere fact that such a campaign has attracted patients to clinics demonstrates its value. The existence of a strong local social hygiene council, to whom the education has been entrusted, however, has resulted in more than this. It has meant that a group of interested citizens have been kept busy correcting, one by one, deficiencies in legislation and social organisation as they are called to their attention by means of investigation carried on in the clinics.

Some examples will be in order here:

Very early it was discovered that to attempt to control venereal disease with no legislation was difficult if not impossible. Legislation was obtained by calling the necessities of the case to the attention of the same group which now carries on the local social hygiene council. The legislation provides for notification and compulsory treatment just as does legislation concerning other communicable diseases, although there are certain safeguards rendered necessary by the nature of the disease. For example, the physician is not required to report his patient by name unless treatment is neglected. Very great care has been exercised to avoid discrimination against women. It is interesting to note that actually more men than women have been dealt with under this legislation.

For example in a single year the figures are as follows:

#### Cases Brought Under Act

(a) Report on suspect cases of V.D.	130
(b) Report with diagnosis to secure treatment	92

	Male	Female	Total
Syphilis	50	15	65
Gonorrhoea	6	16	22
Both	2	3	5

#### Prisoners in Custody

Total number cases in 1927	1503
Men's Farm	1250
Women's Farm	173

#### Results

	Male	Female	Total
Syphilis	55	32	87
Gonorrhoea	17	15	32
Both	1	9	10
Negative	1205	169	1374

#### Total Number of Venereal Disease Cases Reported by Serial Number by Private Physician, Hospital Clinics, and Jail.

Year 1927

	Male	Female	Total
<b>Hospital Clinics—</b>			
Syphilis	243	144	577
Gonorrhoea	327	155	482
<b>Private Physicians—</b>			
Syphilis	39	65	104
Gonorrhoea	141	77	218
Chancroid	0	0	0
<b>Jail Physicians—</b>			
Syphilis	56	41	97
Gonorrhoea	18	24	42

#### Summary—

Total number of cases of Syphilis reported	778
Total number of cases of Gonorrhoea reported	742
Total number of cases of Chancroid reported	0

At the time of the passage of the Ontario Act for the Prevention of Venereal Diseases there was a feeling in some quarters that it might be used merely for the purpose of attacking the prostitute class.

A study of the above figures will convince one that it has not worked out this way. In Toronto the question of crime, and that of public health have been kept separate, and in the operation of the Ontario Act for the Prevention of Venereal Disease the person alone is dealt with. Neither sex is specifically mentioned in the Act.

This does not mean that the voluntary group is not interested in preventing discrimination against women when the question of prostitution is dealt with. The venereal disease problem and the prostitution problem are closely related and the local social hygiene council in addition to its broad educational programme has under consideration from time to time the matter of laws and machinery having to do with fair treatment for both sexes. The double standard of morals is likely to be in evidence even in the way the two sexes are treated in police court, and I would suggest that the appointment of a woman magistrate may be one way of seeing that men and women are treated alike.

As regards the police policy towards prostitution in Toronto it has been one of rigid repression for a good many years now. As a result organised prostitution has disappeared. Clandestine promiscuity there is, of course, but the commercial aspect is very little in evidence. One may readily arrive at an opinion on this matter by a casual investigation among patients attending the venereal disease clinics in any of the hospitals.

May I in passing pay a tribute to the influence of the woman magistrate. The presence of a woman physician on the bench (Dr. Margaret Patterson) has been of very great value in developing a proper point of view in Toronto towards both the male and female sex offenders. May I make bold to suggest that while I have every respect for woman's influence in the home, I have little sympathy for those who would limit her influence outside the home. Dr. Patterson is a good example of how effective such influence can be.

The venereal disease clinic in a general hospital provides many opportunities for effective service beyond the mere treatment and limiting of a communicable syphilitic or gonorrhoeal infection. Such an infection extending over a period of years means that probably extensive physical and perhaps mental damage has been done. We make it a rule to undertake the routine physical examination of all patients attending the clinic and the cardiac, neurological and other complications unearthed are very numerous. Frequently damage has been so serious that complete repair is impossible, although the progress of the disease may be checked. The essentially important work of the clinic, however, is to diagnose, treat and keep under treatment the early case.

Some reference has been already made to the means to be adopted for keeping such cases in particular under treatment. Here it seems to me that the most important factor is education, and the poster, the lantern slide, and proper distribution of literature all

play their part. None, however, are as important as the heart to heart talk with the clinic physician on the occasion of the first visit. A careful description of the danger of the disease and the urgent necessity for regular treatment are essential. The graduate nurse social worker is, of course, invaluable. She is an essential part of the clinic machinery which indeed would fall down altogether without her. It is seldom necessary to resort to the actual use of the venereal legislation, but the fact that it is available has a most stimulating effect on patients who would otherwise be recalcitrant.

One difficulty which exists probably in most venereal disease clinics is inherent in hospital and particularly out-door structure. Most of our hospitals were built before the venereal disease problem was discovered. Particularly in this disease privacy is desirable for investigation by either the physician or the nurse social worker. The cubicle system clinic would seem to be ideal although I know as yet of no hospital in Canada where it is in actual operation. Under such a system the conditions approximate those in practice. The patient can tell his or her story privately to the physician without any of the reserve which is inevitable in many clinics where conditions are more like those before a department store bargain counter than in a physician's office. In such a clinic fashioned I should think along the pattern of St. Thomas's Hospital, London, Model Venereal Disease clinic, the physician can take histories himself and examine, diagnose and treat patients assigned to him. Patients should be seen always by the same physician for obvious reasons. The cubical system makes this arrangement easy.

The following case provides a sample of the sort of information which may be elicited by careful investigation. A woman from a place about two hundred miles from Toronto, while a patient in the Toronto General Hospital, was found to have a positive

Wassermann reaction. By communicating with her family the following condition of affairs was revealed:

Mrs. J. S.—Mother—V.S.P.  
 Father—died—G.P.I.  
 Eldest child—Negative.  
 Next child—V.S.P.  
 Next child—Negative.  
 Next child—Negative.  
 Next child—V.S.P.  
 Next child—Negative.  
 Next child—V.S.P.  
 Next child—Negative.  
 Next child—Negative.  
 1 daughter-in-law—V.S.P.  
 1 daughter-in-law—Negative.

By correspondence and co-operation with the health authorities it was found possible to get these patients under treatment. I need scarcely say that often before syphilitics are discovered the disease has already done a great deal of damage—more than in this family.

The following is a further example:

Case 2—Father, first reported—G.P.I.—In asylum.  
 Mother—V.S.P.  
 Bertha, aged 15—V.S.P. Inter. Keratitis.  
 1 baby died—Enlarged Liver.  
 1 child, age 12—Juvenile Paresis—V.S.P.  
 1 child, age 9—V.S.P.  
 1 child, age 6—V.S.P.

Mothers' pension has been granted. The above are all public charges.

In Toronto the machinery for dealing with such cases is simple. It is not quite so simple in the smaller cities or districts, although here too there is machinery.

Six hospitals with properly staffed venereal disease clinics with social workers attached, working together in co-operation with an efficient department of health plan, good venereal disease legislation means a strong construction. A case of syphilis reporting at a hospital not only ensures the effective treatment of that case but in addition may make possible and even likely the examination of sources and numerous contacts. Such work carried on continuously will ensure the diminution of the incidence of venereal disease in a community.

The question of prophylaxis is much discussed in some countries, and army methods during the war have resulted in an occasional demand for it. Generally speaking, in this country we have avoided stressing it and there would appear to be no reason for entering into a controversy anent the virtues of the prophylactic packet at this time. At the same time, there is no doubt that the person who has been exposed to a possible infection should report to a physician or a clinic at once, and I see no reason why local educational propaganda should not include information to this effect. In such cases the use within a few hours of calomel ointment and permanganate solution will prevent infection. It seems to me, however, that even the advertisement of this fact unless it is carefully done may do harm in a civil community. Properly handled it should be of value.

Through one's everyday contact with the patients in a venereal disease clinic one develops a point of view towards the venereal diseases themselves. One can only see them as a great national problem which neglected means tremendous losses to Canada from unnecessary disability and death among her citizens. Nor can we fail to be impressed by the sad procession of children who, if they live will lead sadly blighted lives, suffering from disabilities of which they are the innocent victims. One cannot but be heartened by the knowledge that Canada has a venereal disease programme in which the Dominion and Provincial Governments have co-operated successfully for a number of years, with the result that no less than 200,000 persons have been reported as having been brought under treatment to date. Nor can one but feel that we should go much further. For what of the still remaining vast army of persons who already infected, unaware of their condition, are likely to suffer more themselves and pass their infection on to further victims? This simply means that we must not let up on our efforts. May I in

passing say that only by adoption of a national method of stock taking can we achieve results. (I am not now speaking of venereal disease only.) We know that because of this fact incipient disease of all types develops unnecessarily into serious conditions which fill beds in hospitals and institutions for the defective, with persons who should be well. I can see no other cure for it than the adoption of a national periodic health examination scheme. Only by such a method resulting in the discovery of ailments often at the time trivial can we hope to materially extend our average length of life, and in the absence of a scheme of this type I do not see how such can be stamped out.

We may say, what about the relationship of the venereal disease problem to morals? What about teaching sex hygiene? Do our young people know enough? My answer is that I am not an ardent supporter of sex hygiene as it is commonly or at least too often taught. In many cases our young people know too much already. There seems to be nothing left to the imagination, nothing sacred, nothing good any more. Certainly this is the impression one gets from reading a large proportion of our current fiction. Where training is necessary in the case of children, it should be left in the hands of the parents who, of course, should not be left entirely uninformed.

Parent training we need, and parents among other things should be able to guard their children against sex mishaps. But there is more than that. Health, character formation, preparation for marriage, and the ultimate assumption of the duties of parenthood are needed by our young people. If they can be made to realise their responsibilities for the carrying on of a finer and healthier race of wiser people the problem will be solved. Certainly it will not be solved by the vaporings of a certain misguided gentleman from Denver—truly a blind prophet attempting to lead us into morasses and ditches from the filth of which we may have difficulty cleaning ourselves. I believe that the

eugenic's ideal is more to the point. We must strive to build up a better race if we would even achieve a higher average of happiness for the average person. And health teaching and teaching as to the significance of so ruling our lives that our mating may be pure and normal, will do more than our somewhat sentimental morality of the past. When we realise that the broken home, whether the result of death or divorce, is an evil from which we will suffer as a nation and as a race for generations to come, and take steps to prevent it by proper education we shall be on the road to success. For the home is the nest whence springs all future life and for the sake of the future we should strive to keep it not only intact but pure.

To this end health must be stressed more and more as the years go on. Money, in so far as the human race is concerned, is but a means to an end, although we would scarcely think so listening to the deliberations of the average body of law makers. That the first duty of a statesman is the preservation of the health of the people has been considered a truism. It should be held seriously to be a fundamental reason and basis for government. Some wise person once said that the ideal government would be one composed of doctors and women. Certain it is that in the absence of sound public opinion the health machinery of our country will be weak. In the absence of good health machinery, including strong official departments of health, the great problems we are discussing cannot be solved. If they are not solved we will be slow in building up the strong race of Canadians we should have if we are to take our place among the great nations of the earth. For no nation is greater than the people who make up that nation, and no person is greater than his environment and his heredity permit. So that my final opinion is that the doctors and the women who, after all, know more about these things than most people should have more to say about it in the future than they have had in the past.



## Nervous Troubles of Children

The British Journal of Nursing, April, 1929, reports most interestingly Miss Mary Chadwick's lectures to the British College of Nurses on "Past and Present Views concerning Nervous Diseases."

In discussing the nervous troubles of children and how the nurse may help them, Miss Chadwick says:

"In reviewing the incidence of neurosis in childhood, we may ask ourselves four questions:

"1. What are the neuroses of childhood?

"2. What are their predisposing causes?

"3. How soon may the symptoms develop?

"4. What can the nurse do to help these children?

"1. *What are the neuroses of childhood?* These are often unrecognized as such, but when we examine them carefully we observe the symptoms to be identical with those which are present in the adult neurotic. Thus we may find the juvenile hysteric, usually considered a spoilt, highly-strung child, who rules the house alternately with temper or tears, attacks of breathlessness, or loss of appetite, who is always seeking attention or sympathy; possessing fears innumerable, the early form of *anxiety hysteria*, or already showing *conversion hysteria* in headaches, periodic vomiting, general malaise, growing-pains, etc.

"We may also see the little *obsessional neurotic*, under compulsion to touch things, to say things or to ask innumerable questions and plead for reassurance that he or she hasn't broken anything or looked at something that was forbidden. *Melancholia* will also be found in quite young children, who feel unwanted or that life offers endless disappointment without compensation, because, perhaps, a new baby has alienated a certain amount of love that was once undivided. The child's wish to escape from the difficulties of life will often appear in

dangerous recourse to phantasy, and the avoidance of real life that we may recognise in rather later stages of development as *dementia praecox*.

"2. *What are the predisposing causes*, and 3. *How soon may symptoms appear?* may be taken together for the most part.

"Some of the most important of the predisposing causes of child neuroses are tendencies to nervous trouble in the parents, or those who have charge of the child during its early years. Modern research has shown us that the parental attitude towards an infant will become readily impressed upon the character of the child. Thus we will find the baby who came unwanted into this world, or with whose sex the parents were dissatisfied, gains this impression at an early age and shows it in future unhappiness or expectation of failure. Again, the feeding of the infant will influence early character development, in that the well-nourished infant grows up more contented and nervously stable than the marasmus baby, or one who has suffered early and severe deprivation in this respect. The same anxious expression on the face of the baby with digestive troubles is easily recognised upon that of the adult who is afflicted with anxiety neurosis, accompanied with fears of all descriptions, especially that of the uncertainty of life. The early training of the infant, through love or punishment for cleanliness and other good habits, if urged too soon or too insistently, will sometimes lay the foundation of over-conscious tidiness or a scrupulosity concerning dirt, doubts or other obsessions, as well as exaggerated guilt and fear.

"*The great triangle of the Oedipus Conflict*, of father, mother and baby, with baby struggling to be the most important side, supported by the other two, is the basis of a large percentage of youthful as well as adult neuroses, especially hysteria.

"4. *The nurse's part in child neurosis* differs in some ways considerably from that which she plays in the nervous complications of adults, because in these difficulties she is faced frequently with the problem of altering the attitude of the parents towards the child; while in adult nerve cases the patient continues as a child

and to react to old situations that are no longer real for the present time and from which the patient must struggle to free himself or herself without the interference but with the help and encouragement of the nurse, who may point out this repeated situation which is the cause of so much trouble."

## *Poliomyelitis*

During the height of the epidemic of poliomyelitis in Winnipeg in 1928 a number of brief articles on the nature and treatment of this disease were prepared for publication by a committee of the Winnipeg Medical Society. These articles also included in a recently published report of that epidemic are reprinted forthwith:

*Nature of the Disease:* Infantile paralysis, or poliomyelitis, as the name implies, is an acute inflammation (itis) of the grey matter (polio) of the spinal cord or marrow. It is more than this, however. The inflammation may extend upwards so as to affect the vital centres in the lower part of the brain, thus leading to paralysis of respiration which is the common cause of death. Sometimes, especially when the disease appears in epidemic form, the brunt of the attack may fall upon these vital centres, and there may be no sign of the paralysis of the arms or legs, which indicates injury to the spinal cord in the ordinary case. But the infection is even more widespread, for evidence of the action of the virus or germ which causes the disease is found in many other organs besides the brain and spinal cord. The modern conception of the disease is that the infection, probably gaining entrance through the nose and throat, is widely diffused throughout the body, that in only a very limited number of persons does the infection reach the brain and cord, and that persons showing no paralysis nor other evidence of disease of the nervous system may act as carriers.

The pathological changes in the nervous system are inflammatory in nature, and quite similar in kind to those of sleeping sickness (encephalitis) and other inflammations of the brain and cord. As a result of the inflammation, the nerve cells in the cord which supply the muscles of the arms and legs are destroyed, and there is more or less complete paralysis. It is seldom that all the cells in one area are destroyed, so that the paralysis is often merely partial, and under efficient medical treatment there may be a remarkable degree of recovery. Only the cells supplying some of the muscles of one arm or one leg may be involved, and in these cases recovery is still more complete. There is therefore no mystery about what we may call the pathology of the disease.

*Its Cause:* When we come to the question of causation we must tread more warily, although still with a good deal of confidence. In 1910, Simon Flexner, of the Rockefeller Institute, found that when infected material from the spinal cord of a fatal case was injected into a monkey the animal acquired the disease, and that the infecting agent, or virus as it is called, would pass through the pores of the finest filter. It belongs, therefore, to that group of the most minute germs known as the "filter passers." Noguchi, the distinguished Japanese scientist of the Rockefeller Institute, who recently died of yellow fever while investigating that disease on the West Coast of Africa, succeeded in making a culture of the virus, and

this, when injected into monkeys, reproduces the disease in the animal. The reason the monkey is used is that no other animal appears to be susceptible. Other views have been expressed about the causal agent, but none have the convincing quality which characterises the work of Flexner and Noguchi.

*Method of Spread:* While we are on firm ground in considering the pathological changes in poliomyelitis, and are fairly certain as to the causal agent, we are still very much in the dark as to the method of spread. The general belief is that the disease is spread by contact, but it is very difficult to prove this. It has already been pointed out that the infection may be conveyed not only by those suffering from definite inflammation of the spinal cord, but also by others who may have manifested none of the ordinary signs of the disease, and even by perfectly healthy carriers. Others believe that the infection may be spread in other ways, but here, even more decidedly, there is no shadow of proof. Ignorance regarding the method of spread makes it difficult to take rational steps in the matter of prevention. The same, however, is true of other diseases, such as influenza, cerebrospinal meningitis, and sleeping sickness.

*Treatment of Poliomyelitis:* With the first symptoms of the disease it is important that the child be placed at complete rest. If the patient is allowed to move about, there is danger of more damage to the nerve centres. The treatment at this time is that for an acute febrile condition, as directed by the physician. Further, immediate treatment of the disease is directed towards the prevention or limitation of the paralysis which is the result of the action of the poliomyelitis virus on the nerve cells.

It has been found that the blood of persons who have recovered from the disease has a neutralizing action on this virus. Based on this experimental evidence, individuals struck down

with poliomyelitis have been treated with the serum from the blood of people who have recovered. This serum is called "convalescent serum" and has been used extensively in several previous epidemics in various centres. The evidence is that this serum, when administered quite early in the attack, has a beneficial effect in many cases.

The results indicate that occasionally it may prevent paralysis. Following the use of the serum, a lower mortality rate is noted. Moreover, there is a lower average total paralysis, and a lower incidence of paralysis of the severer grades. The effectiveness of such treatment depends upon an early recognition of the condition and the use of the serum in the pre-paralytic stage of the disease. It is considered that the serum has little value once the paralysis has set in. The available supply of such serum, obviously, may be limited, since it can be obtained only from those who have recovered from infantile paralysis. Antibodies to the virus which causes the disease have been found in the serum of persons who have had the disease over 30 years previously. The most valuable immune serum, however, is considered to be of the donors whose attack occurred from a few weeks to several years previously.

From what has been said, it becomes evident that those who have recovered from a previous attack of the disease are in a position to confer a great public benefit by giving a comparatively small quantity of blood that is needed for the treatment of children suffering from this dread disease. The removal of this small amount of blood is without injurious effect on the person who gives it.

*Symptoms of the Disease:* In the cases of infantile paralysis occurring in Winnipeg the most prominent initial symptom has been vomiting. The vomiting does not necessarily accompany every case. Associated with the vomiting is a prompt rise of temperature at varying intervals from 101 to 104 degrees Fahr. The vomiting may

occur only once or may be repeated at varying intervals for a period of twelve to twenty-four hours. As this is the season of the year when attacks of indigestion most commonly occur, the parents frequently are not alarmed, and with younger children they ease their anxiety by the fact that the child is teething. In contrast to the usual attack of indigestion, diarrhoea does not follow, but the child next day remains constipated, the temperature remains elevated and the child still appears ill. The child may be irritable, as indicated by crying or tossing about in his bed, but on the other hand he may be very drowsy, taking no interest in surroundings or his food. Above all, he is willing to stay in bed, which is in direct contrast to his behaviour in those ordinary infections of childhood that are accompanied by vomiting and temperature. If irritable and old enough the patient may complain of headache or pain on movement of the neck, not as a rule if the neck is moved from side to side, but only if attempts are made to bend his neck forward to take a spoonful of food or for any other reason. He may refuse to sit up, or if he does so, does it with difficulty, raising himself by means of his hands, at all times holding his back rigid, and he will complain of pain if asked to touch his toes with his fingers while in the sitting position.

In a very few cases sore throat has been the initial complaint, but in such cases examination reveals only a slight redness, not sufficient to account for the temperature, and further examination reveals pain in the neck or in the spine on forward movement.

Whenever any of these so-called "pre-paralytic symptoms" of the disease are noticeable they should warrant an immediate consultation with the family physician, who can then institute measures to confirm the diagnosis by an examination of the spinal fluid.

A still more severe type of the disease is known as the bulbar type of

infantile paralysis. The onset is very sudden, usually with vomiting and temperature. In a few hours there is noted a great difficulty in swallowing, along with the usual neck signs. There may be a paralysis of one side of the face, and paralysis of one-half of the body may rapidly follow. If the paralysis spreads to involve the muscles of breathing, death rapidly follows.

It has been recognised in previous epidemics elsewhere that the use of convalescent serum not later than forty-eight hours after the onset of symptoms tends to prevent or lessen the subsequent paralysis, but once paralysis has made itself evident, which usually occurs three to seven days after the onset of symptoms, treatment by the use of convalescent serum is of no avail.

There is another type of case, who simply appears out of sorts, a little more irritable than usual, does not take his food well, and his temperature may be normal. In four or five days the mother notices that he does not walk well, has difficulty in going upstairs, and if laid on the floor has difficulty in rising to the standing position. Cases of this type can now be regarded as mild attacks of infantile paralysis, as evidenced by general muscular weakness. A child with such symptoms should be put at absolute rest in bed, in order to give the muscles the best opportunity to recover.

*Treatment of the Paralysis:* Treatment during the acute attack has been fully discussed in previous articles. The management of the patient in the weeks and months after the illness is over will now be considered.

The first thing to realise is that marked improvement during this period is to be expected. Little patients who have one or more limbs completely paralysed at the beginning practically always improve, and indeed may even go on to complete recovery. Although many patients are unable to walk at first, it is very exceptional



to see one who cannot eventually be got on his feet. It is well to remember the bright side of this all too gloomy picture, and to realise that there is every reason to look hopefully to the future.

It cannot be too strongly emphasised that these children should be under constant medical or surgical supervision until they have recovered as far as possible. This means for weeks at least; more often for months and years. It is especially during the first weeks that much good can be done by proper management, but that but there are two very important much harm will result from neglect or from following bad advice. No attempt is made in this article to tell parents how to treat their children, points in the treatment that should be emphasised.

The first is that rest is the sheet anchor in the treatment. This means rest in bed. How long a period will depend upon many factors, and will be determined by the doctor in each individual case. The second is that the paralyzed limbs must be splinted in such a way as to prevent overstretching of the paralyzed muscles.

and to prevent the occurrence of deformity. Again the doctor must determine the character of the splinting for each individual case.

When these two things, rest and splinting, have been instituted, nine-tenths of the treatment during the first few months is arranged for. Considerations of other methods of treatment are of minor importance. The diet should be light and suited to the age of the child. No specially nourishing food is indicated; it is better for these children not to become fat. Mothers are urged to give forced feeding because the child is weak. This is a mistake. The various forms of electrical treatment may be useful at times, but the indiscriminate use of electricity in this disease has done a lot of harm in the past. There comes a time when most patients are benefited by massage, but if begun too soon, or carried out without a full appreciation of its effect upon the individual patient, massage can do positive harm. All these accessory methods of treatment must be carefully prescribed by the doctor, and must be regarded as adjuncts only of the main things, which are rest and splinting of the paralyzed muscles.

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## *Diet in Disease*

By E. LAURA CODY, B.H.Sc., Assistant Dietitian and Theoretical Instructor,  
Victoria Hospital, London, Ont.

Today, dietetics has assumed such importance in the treatment of disease that the nurse finds it absolutely essential to keep in touch with the newer developments. So much has been brought to light within the last few years through experimental work on feeding of animals, from which humans have derived benefit, that a realisation of the importance of dietary measures in disease is universal.

In no disease does diet assume such prime importance as in diabetes; it also holds an important place in the treatment of nephritis, pernicious

anemia, gout and diseases of the digestive tract.

### *Diet in Diabetes*

Diet, not drugs, is the mainstay of any successful treatment of diabetes. Insulin must always play a subordinate rôle to dietetic measures.

The principles underlying the dietetic treatment:

- (1) Provide for the energy requirement of the patient. This is governed by the age, size, sex and activities of the individual. (A man engaged in moderate work requires 2,500-3,000 calories per day.)

(2) Counteract any obesity. Many diabetic patients, especially elderly ones, are overweight, so, in calculating the diet, it is well to allow them the energy requirement of the average individual of the same age. Strive to keep the patient just under normal weight.

(3) The protein requirement must be fulfilled whatever the diet. This will provide the tissues with building material to prevent wasting. (One-half a gram of protein per pound of body weight is a safe margin.)

(4) The proportion of fat to carbohydrate in the diet should not be too great: one must prevent the development of ketosis or acidosis. Two courses of procedure are open:

(1) Starvation or under-nutrition method of treatment. In this case the patient is allowed meat broths, tea or coffee without sugar, and carbohydrate-free articles of food of low nutritive value, as wafers and muffins. This is continued several days till the sugar disappears from the urine. When this occurs, the diet is built up gradually until a suitable diet is reached. Insulin may be required to accomplish this end.

(2) The other method is to place the patient at once upon a diet providing the required amount of energy, and enough insulin administered to keep the urine free of sugar.

The nurse, in order to co-operate with the physician, is required to have a working knowledge of dietetics. The desires of the patient, customs and laws of religion should be observed, individual tastes are to be considered, and one must remember that the purpose of the diet is defeated if the patient refuses to eat and may be defeated if he does not relish the food.

In constructing the diet, the carbohydrate quota should not be taken in concentrated form; a larger part should be in the form of 5% or 10% vegetables and the smaller part in

15% vegetables and fruits. Vegetables are of definite value in giving the necessary bulk to the diet. If the amount of carbohydrate permitted is liberal, breakfast cereal may be included, also potato, but no sweets should be permitted.

Proteins may be taken in almost any form: meat, eggs, milk or cheese. The fats are most agreeably taken in the form of butter and cream; considerable would be accounted for in the bacon and eggs used.

The foods should be easy to obtain, simple and digestible. Articles of diet should be such as are commonly found on the normal menu. The menu should provide variety: elasticity in the choice of food is essential. It is often better to use slightly less than the prescribed amount of food, leaving a margin to be used as extras to vary the diet. Vegetable salads taste very different when enriched by the addition of a portion of lobster, a small ball of cottage cheese, a sardine or shrimp, an olive or a small piece of Canadian cheese. Salted almonds or chopped nuts might be added to a fruit salad. The actual caloric value of these extras is very meagre, but they are of immense importance in increasing the palatability of the diet.

In planning for variety in the fruits and vegetables on the menu, a handy table of the carbohydrate contents of the various fruits and vegetables will prove a wonderful help. Such a table has been assembled and placed on a small card by Dr. Joslin. (These cards are published by Thos. Groom & Co., 105 State Street, Boston.) The 5%, 10%, 15% and 20% fruits and vegetables in common use are listed, and one may substitute, when desired, another fruit or vegetable of the same group.

Should other conditions arise whereby the diet given should be soft or bland, the nurse's power of adaptability will have to be exercised. Still, the use of milk, cream and eggs in various combinations, and sieved vegetables, may fulfill the requirements of the individual.

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

### *The Teaching of Bacteriology*

By RUTH F. WALDEN, Instructor, School of Nursing, Royal Alexandra Hospital, Edmonton

The correct understanding of the more important facts and principles of bacteriology, one of the most vital subjects in the curriculum, is an indispensable part of every nurse's mental equipment. To stimulate the interest for the acquiring and retaining of this, the teacher must create a necessity on the part of the students by stressing the responsibility of nurses to protect themselves, their patients, and the public. This would be made more obvious to the student by a few dramatic stories regarding septic cases, typhoid epidemics, etc. If the students realise their need for bacteriology, it is easy to find a market for the course. To find a market implies an exchange, an article wanted and that want supplied.

It is generally agreed that, to obtain the best results, bacteriology, being a fundamental science, should be placed in the preliminary period when the students show an interest never displayed later in their training. If presented properly, the knowledge of these minute organisms is a revelation to them which should be applied from the beginning in their work, and should stimulate them to read and study regarding the newer methods and discoveries.

The course should be given by a physician or laboratory technician, and applications made by a nurse, or, preferably, a nurse instructor who has had special training in bacteriology and allied subjects.

The time allotted varies with the different hospitals. Forty-five hours in three-hour periods, one of lecture,

one of demonstration, and one of laboratory is ideal, but fairly complete courses can be given in twenty-five or thirty hours. As the facilities in many hospitals, as yet, are inadequate, the laboratory periods in them will have to be curtailed, but demonstrations can always be given to illustrate the lectures.

An outline of the course should be arranged in topical sequence for the number of class periods, beginning with green plants and molds for an appreciation of cell structure and life, and leading to the more advanced study of bacteria in relation to disease. This outline should correlate with other subjects and prevent overlapping.

Lesson plans may be made out in outline form for each period. These should contain the topic, problem, aim, name and pages of reference material for teacher and for student, illustrative material and where it is located. These may be kept from year to year and improved upon with the development of science and of the teacher's ability.

A text book such as "Applied Bacteriology for Nurses," Bolduan and Grund, or "Bacteriology for Nurses," Morse and Frobisher, may be used and supplemental reading assignments be given in the more advanced books on this subject. Assignments in reference or text books should be given previous to the lecture on that particular topic so that the students will come prepared to get the most from the class.

Note books should be required, in which the notes from lectures in outline form are kept along with notes

of reference reading in similar form. Laboratory drawings, coloured and labelled, may be kept in this, or under a separate cover. These books should be handed in weekly, corrected and returned to the student.

The principles of bacteriology must be made real to function properly. They should be taught and associated in the mind of the student in relation to their use. A few students may apply them but the majority must have them presented in connection with related subjects. They should be applied to methods of disinfection, to sterilisation of water, instruments, dressings, and to the care of discharges and excretions. Applications should also be made to the serum used in prevention, diagnosis, and treatment of the infectious diseases.

Many demonstrations to illustrate the lectures may be arranged easily and inexpensively, for every hospital has a wealth of material. A leaf may always be obtained for cell study. Onion, potato and carrot experiments are easily arranged to illustrate osmosis and dialyses. The laboratory technician will usually provide agar plates and broth for mold cultures. Swabs of students' teeth, fingers, nasal passages, etc., demonstrate the unthought of presence of bacteria. Agar plates opened in different places such as operating room, ward and nurses' home, show the presence of bacteria in various environments. Swabs taken of students' hands before and after scrubbing will demonstrate the necessity for this. A pure culture may be started, examined each week and transferred, if pure. Different types of milk and water may be plated and bacterial counts taken. Prepared slides from the laboratory may be secured for streptococcus, staphylococcus, pneumococcus, bacillus typhosus, etc. Charts and illustrations in other text books may be used to advantage. As learning takes place by the eye as well as the ear, the more frequently illustrative ma-

terial is utilised the more the students will be able to visualise and thus retain and have a better understanding of this all-important subject.

As many microscopes as are available in the hospital should be utilised by the class. The students should have practice in their use as well as the making of mounts. Aseptic technique thus taught in bacteriology will carry over to operating room and ward work. If the equipment is limited so that the teacher only does the experiment, the students will not derive as much benefit because learning takes place while doing. Drawings of the more interesting microscopical mounts will also assist the students to remember and recall the problem involved. In most hospitals the students will not be able to make drawings from individual microscopes. In that case, after they have seen the mount, it may be drawn on the blackboard for them to copy and label.

The classes are conducted by the lecture, discussion, quiz and project methods. The lecture saves time in presenting new material, and is valuable to sum up, clarify and supplement discussions. The discussion method brings up problems of the students and helps correlate the ward with the class-room. It creates initiative in thinking and gives practice in self-expression. The quiz method is valuable as a review and to discover erroneous ideas which need rectifying. Several thought-provoking questions should be prepared previous to the class period. The project method links up class and ward work. The student chooses her project, solves it on the wards, and reports the results in class; for example the strength, use, characteristics of a certain disinfectant which is being used on her ward.

Where possible, the laboratory method may be used to supplement the lecture and help correlate the theory and underlying principles with practice. Individual work gives



training in the scientific method and in taking responsibility.

Students should keep a pathogenic chart which they may use in communicable diseases later. These should contain characteristics, incubation period, portal of entry, mode of conveyance of the causative organisms of the various diseases as well as characteristics of the disease.

A history of bacteriology may be given in the first or in the last lecture for appreciation of this comparatively new science.

Excursions should be used more than they are. Excursions to a milk plant, packing house, city water source, well-equipped laboratory, and the fumigation plant of the hospital, are valuable and help the student to apply her knowledge in a real situation. In order to conserve time and to get the most educational value from these trips, the instructor should plan the route beforehand and each student should know just what she is to look for. These may be checked on return by a quiz, or an oral or written report.

Frequent tests should be given to judge the results of the teacher's work and the student's grasp of the subject. True-false tests may be given on the previous lecture at the beginning of a class period. These are economical of class time and provide a good method of testing. As much time is spent in the proper preparation of these, they should be kept and improved upon. The ease in correction compensates for the time in preparation. The final examination should cover the course but credit should be allowed for the tests during the course.

Bacteriology is a practical subject and should not be taught with the idea of a passing mark at the end of the course, but rather with the view of its application and functioning in the work of the students. Unless the main principles are stressed and overlearning provided for, and the students realise their duty in protecting themselves and those they come in contact with, a bacteriological conscience will not be one of their assets.

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## *How Florence Nightingale's Birthday was kept in Central China*

By GLADYS STEPHENSON, S.R.N.

Just one year ago four small Schools of Nursing that had functioned for many years were amalgamated into one Union School of Nursing in connection with the fine new up-to-date hospital that marks the union of the medical work being done by the London and Wesleyan Missionary Societies in Hankow.

The first group of nurses to graduate since the union was accomplished received their diplomas at the time of Florence Nightingale's anniversary. As May 12th, the actual day of her birth, fell on a Sunday, the graduation ceremony took place on Saturday, the day before, at the Community Church Hall in Hankow.

For weeks beforehand preparations had been made, invitations issued, and the nurses had eagerly looked forward to this great day which marked the recognition of past achievement and the promise of future usefulness.

The Hall was gay with flowers, and overhead hung the red and gold satin banner with the name, "Hankow Union School of Nursing," inscribed on it. To the strains of the procession-al, a body of sixty nurses, dressed in full uniform, marched up the aisle to the seats in front, making a very impressive sight.

The chair was taken by Bishop Logan H. Roots, and the service began with the singing of the Nurses'

hymn, "Gracious Spirit, dwell with me". The address was given by a prominent Chinese Wesleyan minister, whose splendid exposition of the ideals of a true Christian nurse was at once a challenge and an inspiration.

The diplomas, tied up with red and gold ribbon (the colours of the Nurses Association of China), were presented by a well-known lady of the community.

Some musical items, one given by a group of the nurses themselves, added much to the enjoyment of the ceremony.

At its conclusion, one hundred and fifty guests partook of the sumptuous tea contributed by the ladies of the community.

In the evening, after returning to the hospital, a Chinese feast was given to the Staff by the happy graduating nurses.

On Sunday, Florence Nightingale's birthday, the usual Sunday service was made a special occasion to commemorate the anniversary of it. The nurses in uniform filled the front pews of the church, and the Chinese preacher, taking the incident of Jesus washing the disciples' feet as his text

told of the life of Miss Nightingale, which was lived in the spirit of "Him who came not to be ministered unto but to minister". He told his congregation how her work had inspired the dawn of an entirely new day in the work of nursing the sick and afflicted of the world. How this work had come with its blessing and happy influence to the Far East, and was helping young China to realise that the Christian nursing profession provided an avenue of service for enthusiastic and well-educated young people who desired to serve their country in some practical manner.

Did not the hearts of the nurses quicken with aspiration at the thought of Florence Nightingale's devoted life of service and her faithful following of God's leading? How much it has meant of blessing to the whole world, yet is it not always thus that the glad yielding of talents in the service of the King of kings makes life very rich, satisfying and fruitful—the only life that is life indeed!

(Miss Gladys Stephenson, S.R.N., is Principal of the Training School for Nurses, at Hankow Union Hospital.—Editor.)

### *Miss Jean Browne in Geneva*

Miss Jean E. Browne, Director of Junior Red Cross in Canada, attended a Conference of the International Junior Red Cross, which met in Geneva, Switzerland, from July 17th to 25th. This Conference was especially called to discuss International School Correspondence, and also other aspects of Junior Red Cross work. Miss Browne was a member of a small consultation committee which

met during the week previous to the Conference.

At the Conference Miss Browne led the discussion on, "The Health Problem as Related to Junior Red Cross."

Prior to sailing for Geneva, Miss Browne attended the meetings of the Grand Council, International Council of Nurses, as one of the official delegates representing the Canadian Nurses Association.

### ANNOUNCEMENT

Announcement is made of the joint meeting of the Manitoba Registered Nurses, Hospital and Medical Associations, on September 9th to 13th, inclusive, at the Royal Alexandra Hotel, Winnipeg.

*Miss E. Kathleen Russell, R.N., B.A.*

Miss E. Kathleen Russell, R.N., B.A., Director of the School for Graduate Nurses, University of Toronto, was among those admitted for

presentation of degrees. Miss Russell gained distinction by winning the right to the degree, Bachelor of Pedagogy.

**BOOK REVIEWS**

This book, entitled "The Art of Bandaging," is clear, concise and practical.

From the introductory chapter on General Uses of Bandages to its final pages on Plaster of Paris splints, is given in detail the various

methods, use for, and application of Bandaging, and so clearly described that the most junior nurse could read and enjoy it. It should prove useful as a reference book on the wards, and as a guide in preparation for examination.—Mary F. Bliss.

## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,

Miss THERESA O'ROURKE, 733 Arlington St., Winnipeg, Man.

### *Immunology and Prophylaxis*

By Dr. W. T. SHIRREFF, Superintendent, Strathcona Hospital, Ottawa

Immunity may be defined as the power which certain living organisms possess of resisting infection; susceptibility is the contrary condition. Immunity or the resistance of the body to disease is the very foundation of preventive medicine. It is the overshadowing factor in hygiene; hygiene being the care of a person, in distinction to sanitation which deals with environment. There are all gradations and kinds of immunity, from the weakest resistance to absolute protection. It also varies in duration from the briefest period to a life span. It may be natural or acquired, active or passive, local or general, pure or mixed, family or racial.

Jenner's observation on the immunity of milkmaids who had had cowpox was instrumental in his brilliant discovery of vaccination against smallpox; but it was not until the discovery of the bacterial cause of many diseases had been proven by Pasteur, Kock, Ehrlick, and a host of other great investigators, that the raising of resistance of the body to different diseases was put on a sound scientific basis.

The relationship of bacteria to disease, and the action of, and the way by which bacteria produce disease, along with the reaction of the body to such, are the fundamental facts which form the basis of the modern methods of combating the invasion of the body by these organisms. The various ways of producing more or less complete immunity to disease are practically all based on the reaction that the various tissues of the body undergo when invaded by the miner-organism itself or when some product of such organism or

protein is introduced into the body. A few definitions are necessary.

ANTIGENS are all substances causing changes in the blood. Antigens are capable of producing antibodies. All known proteins act as antigens when introduced into the body parentally. Examples of antigens are: Smallpox—vaccine, virus; typhoid—vaccine; diphtheria—toxins.

ANTIBODIES are specific properties of the blood and other body fluids induced by antigens. They are not necessarily bodies, but physical states of the blood or other body fluids. Antibodies may also be called "immune bodies."

The fundamental process of immunity within the body must all depend on some physical or chemical change, but very little is known of the chemical composition of the substance that plays the chief role, or the physical nature of the change. Suffice to know that from experimental biology the effects are known. The changes likely occur within the body cells and are then conveyed to the blood. We speak of changes in the blood not because they actually occur in the blood, but because these changes are best represented by the blood.

NATURAL IMMUNITY is an inherited characteristic possessed in common by all individuals of a given species. For instance, man is immune to many diseases of animals: rinderpest, Texas fever, hog cholera, etc., while animals are immune to such diseases as measles, mumps, typhoid fever, gonorrhoea, syphilis, etc. Natural immunity may be broken down by various means that weaken the animal; such as, fasting, undue exposure, vitiated atmosphere, etc.



ACQUIRED IMMUNITY is a specific resistance to an infection that is not naturally inherited in all the individuals of a species but is acquired during the lifetime of the individual. It may be acquired through some natural event as an attack of the disease or artificially induced. Acquired immunity may be either active or passive.

Active immunity is induced by:

- (a) An attack of the disease.
- (b) The introduction of a virus.
- (c) By the introduction of a vaccine.
- (d) By the introduction of a toxin or other product of bacterial activity.

(a) The immunity conferred by an attack of certain diseases is quite familiar to nurses, but certain observations may be noted. Some infectious diseases such as erysipelas, septicemia, common colds, do not confer immunity, but rather the reverse.

(b) The immunity conferred by the introduction of a virus into the system is exemplified by the present day vaccination with cowpox (a modified smallpox). The same method is used for Texas fever, anthrax, rabies, etc. The virus in these cases is reduced in virulence, by passing it through an animal; by growing it under unfavourable conditions of temperature, moisture, etc. In this way, a modified form of the disease is created which gives a high and lasting form of immunity.

A distinction should be made between a virus and a vaccine; if the material used contains the living active principles, it should be called a virus; if the material is dead it should be called a vaccine. Most bacteria have adapted themselves to a definite mode of entry into the body and if introduced any other way, fail to gain a foothold. For instance, we know that if typhoid bacilli are introduced to the body in any other way than by the stomach, typhoid fever will not result. Smallpox is a great deal more virulent if introduced in the regular way, by the nasal mucous membrane than by inocula-

tion. The organisms of septicemia and tetanus may be swallowed with impunity but if introduced hypodermically, it is another story. Advantage is taken of this to confer immunity in some diseases.

(c) BY THE INTRODUCTION OF A BACTERIAL VACCINE. The immunity produced by the introduction of a vaccine into the body corresponds precisely to the immunity acquired by the introduction of a virus, the only difference being that the living virus produces a more lasting and higher degree of protection.

Vaccines are usually prepared from a fresh 24 hour culture of the micro-organisms grown on agar. The organisms are killed by subjecting them to a temperature of 60 degrees for one hour. A high heat is undesirable for the reason that it coagulates the albuminous materials in the bacterial cell. Preventative inoculation with such vaccines are now much practised in typhoid plagues, and Asiatic cholera. These vaccines are standardised by counting the cells of the blood. The dose is determined by the number of dead bacteria in a given amount.

(d) TOXINS. A toxin is a specific poison elaborated by bacterial metabolism. It is soluble in water, poisonous in minute amounts when given hypodermically and produces antibodies; namely antitoxins. They are known only by their effects on animals. They have never been isolated in pure form. They are destroyed by heat. Few bacteria in propagating produce true toxins. Diphtheria, tetanus and botulism are the common ones.

A great many of the other common diseases do not produce true toxins but do produce other poisonous products of bacterial activity such as acid, alkali, nitrates, etc. If all communicable diseases produced true toxin it would be quite simple to produce antitoxins to combat them, but unfortunately they do not. Some organisms produce a double toxin, as in diphtheria, where we can separate the toxin from the anatoxins or toxoid.

Toxins affix themselves to the different cells of the body but different toxin seems to have a particular affinity for particular cells; thus diphtheria attacks the axis cylinders of the nerve cells, producing paralysis; while tetanus attacks the cells of the anterior root of the horn. But what I wish to impress is that the toxin once affixed to the cell is not dislodged by the antitoxins. That is the reason for the early use of antitoxins in treatment.

Toxins produce immunity by generating antitoxins. As a rule they do not produce as much local reaction as vaccines, and like vaccines they have to be given in successive doses at varying intervals.

Modern methods of inducing immunity in different ways is well illustrated by the procedure followed to protect against certain diseases:

**SMALLPOX.**—In vaccination against smallpox, an attenuated virus is used. In these cases a live virus is used, which is introduced intradermically. After a period of incubation a local and systematic reaction takes place, with the result that antibodies are produced. Only one inoculation is necessary to produce the desired result, and the immunity produced is both lasting and positive. In a personal observation of thousands of cases I have yet to see a case of smallpox in any person successfully vaccinated within 10 years.

**DIPHTHERIA.**—It was some years after the discovery of antitoxins before a method of producing a more or less permanent immunity to the disease was devised. At first an effort was made to produce immunity in the same way that antitoxin was produced, by the injection of the toxin. But this was found to be too dangerous. Later, the use of what is called toxin-antitoxin was devised. Antitoxin being a mixture of toxin and antitoxin in which the toxin was almost wholly neutralized by the antitoxin.

In inducing immunity to diphtheria by this method the procedure is controlled by the Schick Test in children over seven years of age.

Under six years, the Schick Test is not necessary. This is especially important in adults as rather severe reactions may be encountered. Three injections are given at intervals of a week to ten days, the last two being twice the strength of the first. The immunity created has been found to be about 80% perfect and lasts some years.

More recently, advantage has been taken of the fact that the diphtheria toxin can be divided into the poisonous toxin and the non-poisonous toxoid or anatoxin. The method of separating the diphtheria toxin from the anatoxin has been carefully worked out by the Pasteur Institute in Paris, and a substance obtained which has all the antitoxin producing power of the combined toxin, but is non-poisonous. It also has the advantage of being more stable than the toxin-antitoxin, retaining its antitoxin producing qualities for years. In most cases only two injections of this product are necessary at an interval of three weeks. In exceptional cases a third injection may be required.

In an admirable paper published in the October 6th, 1928, number of the journal of the American Medical Association, Ramon, of Paris, gives a summary of the results obtained in France by the use of this product. Briefly they find that 85 to 90% were immunized by two injections, and 90 to 100% by three. He says, "To date, August, 1928, over a million injections of antitoxins have been given with no serious accidents. Generally speaking, 20 to 40% show very slight reactions, 10 to 15% fair reactions, and 1 to 5% strong reactions. In all cases the reaction being due to protein and not from toxin content.

In contaminated areas, where persons have already been exposed to diphtheria, it is advisable to give a dose of 100 units of antitoxin along with anatoxin. The anatoxin should be given a few minutes before the antitoxin; the subsequent dose or doses of antitoxins being given as usual.

**TYPHOID FEVER.**—As typhoid bacilli in propagating do not produce a soluble true toxin, another method

must be used to produce immunity. In this case the whole killed bacilli, are injected in the form of a vaccine. The dose used is 500,000,000 for the first injection, and 1,000,000,000 for the next three. The injections are given at weekly intervals. Both local and systemic reactions are common, but are never serious.

The protection afforded has been found to be uniformly good, but it deteriorates, and should be repeated in from one and a half to two years. The results of inoculation in the last war were absolutely conclusive.

**RABIES.**—Pasteur's discovery of a means of protecting persons infected with this fatal malady by gradually raising their resistance to the disease during the incubation period, has certainly released this disease from its former terrors. Resistance was produced by injecting daily a freshly prepared emulsion of a virus of gradually increasing virulence. This necessitated the patient in most cases visiting a central laboratory for treatment. The doses were numbered, and had to be given fresh and in proper sequence. Recently the method has been improved and now, 16 to 21 injections are given, all of equal strength; the complete amount required for immunisation being supplied free in one package by the provincial laboratory.

**SCARLET FEVER, ACTIVE IMMUNIZATION.**—Soon after it was generally accepted that the "Dick's" had satisfactorily proven that a form of haemolytic streptococcus was the specific factor in the system complex known as scarlet fever, efforts were made on the basis of experience in creating immunity to other diseases, to create an active immunity to scarlet fever. First it was necessary to devise some method of ascertaining the susceptibility, or otherwise, of the human subjects to the disease. It was natural to proceed much in the same manner as had been done by Schick in testing susceptibility to diphtheria. After some experimentation, a method was devised by Dick. It consisted of the intradermal injection of 1-10 c.c. of 1-2000 dilution of a standard scarlet fever toxin.

In susceptible cases a reaction occurred at the seat of injection, much in the same manner as the Schick, with certain modifications: as in the Schick. This could also be used as a control to the effectiveness or otherwise of active immunisation.

It was also necessary to devise some way of measuring the strength of the toxin. It was decided to measure it in multiples of the amount of toxin required to produce a typical reaction in a susceptible subject. That was called a unit. So the strength of a given amount of scarlet fever toxin is shown as so many Skin Test Units.

Efforts were then made to produce active immunisation by the injection of gradually increasing strengths of toxin at stated intervals; small doses were used at first, and three injections only were given. It was soon found that the immunity thus conferred was both unreliable and fleeting, so both the strength and the number of injections were cautiously increased in an endeavour to secure more lasting protection, if possible.

The procedure in vogue in different places is now as follows: The Provincial Board of Health of Ontario, recommends five injections at weekly intervals.

- First—350 S.T.U.
- Second—1,000 S.T.U.
- Third—2,300 S.T.U.
- Fourth—5,000 S.T.U.
- Fifth—10,000 S.T.U.

Park, of New York, advocates five injections:

- First—500 S.T.U.
- Second—2,500 S.T.U.
- Third—7,500 S.T.U.
- Fourth—15,000 S.T.U.
- Fifth—25,000 S.T.U.

Dick, of Chicago, gives in all, 100,000 S.T.U. in five injections, the last dose being 50,000 units.

The effectiveness of the immunity conferred is tested some two weeks after the last injection by the Dick test, and if not complete, another injection of the maximum dose is given. Dick claims that the immunity conferred is active for at least two years.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
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### *Mental Health in the School*

By E. de V. CLARKE, Reg.N., Supervisor Mental Hygiene,  
Department of Public Health, Toronto

In discussing the mental health of children one must go back to the pre-school days at least, for it is then that the foundations are laid. Miss Davidson in her paper has spoken of the need of educating parents, and the establishment of good routine habits, and I have been assigned the question of the school child.

The mental health of the school child could be discussed from half a dozen angles, but I will only attempt to touch on a few high spots in a very sketchy manner.

The old saying "Train up a child in the way he should go and when he is old he will not depart from it" is as true today as it ever was, and the earlier a systematic training is begun the fewer failures and misfits will result. A good start in school means fewer truants, delinquents and maladjusted pupils in the upper grades.

Until fairly recently little thought was given to this phase, nor was it realised that from the standpoint of both child and school, it was economical to straighten out difficulties at the beginning of the pupil's career, because the problems of the younger children are easier to clear up than the more fixed behaviour of older children. also because the school is spared waste and cost of its efforts through failure of the child to later live up to his capacity for good work and acceptable behaviour.

When a child enters school he has tremendous adjustments to make. He must learn to accept authority, the competition of other children, and to find satisfaction in doing things for himself. So often, until he starts school, the child has lived in a small world where his own wants were

paramount, where most things were done for him, where the protective love of his parents had surrounded him. Then suddenly he finds himself in the impersonal schoolroom and he is overwhelmed by this strange new environment. Here he is only one of many, his own achievements aren't immediately applauded, his demands not catered to, and he has to share the teacher's attention with 40 others. His sense of security is undermined and he is apt to regard his classmates as interlopers whom he attempts to dispose of by the only means he knows—kicking, scratching or screaming—that is his frantic effort to wipe them off the map.

This initiation is a critical point in his career. If forced into submission, it may leave him with an all time unhappy sense of injustice and discrimination. A wise and understanding teacher, however, doesn't use force, although exercising a gentle firmness, she teaches him the satisfaction of doing things for himself, and the joy of doing them well so that he gradually regains his feelings of security from these accomplishments of his own, and is not forced to rely so greatly on personal relationships as he has been doing at home. You must not let a little child get a firmly established feeling of inferiority in his first school contacts—it makes a disastrous handicap.

It is so necessary that a kindergarten and a first grade teacher be a person of great understanding and patience, so she will regard the beginner's attitude as a problem calling for as much time and skill on her part as the problem of teaching him academic work. She has the oppor-



tunity of helping him to discover that authority is not an attack on his personal rights, and a loss of approval and love, but that it is something desirable and necessary for his own good.

Often the teacher has to counteract the influence of a home situation from which many of the child's difficulties spring. It may be there is over-indulgence, discrimination, excessive discipline or lack of it, etc. If the problems of the beginner can be wisely dealt with by a teacher who has a broad interpretation of her job and lifts it out of the routine of simply trying to force the 3 R's into bewildered little brains, she soon acquires an increasing grasp of the most probable causes of classroom problems, and the bugbear of discipline is not to the fore.

It seems obvious that it is necessary to seriously consider some changes in the training not only of teachers but of nurses as well. Both, it seems to me, require very badly to be taught something about the fundamentals of human behaviour; how to recognise and deal with their own personal problems (for who hasn't personal problems?)—and how to approach and help others, through the knowledge gained in realising and overcoming their own. It is a most fascinating and satisfactory subject to study.

Often objectionable and queer conduct in children is due partly to fear. In his confused effort at defense against fear a child may become indifferent, insolent or aloof. The child's fears are specific, not general—that is, a child is not generally afraid, but afraid of a specific object or timid in a specified situation. Doctor Linehan, of Teacher College, Boston, in his book "Training the Emotions Controlling Fear," cites the case of a little girl continually warned by her mother against losing her hankie. The youngster developed undue caution amounting to senseless fear of losing her hankie. She was not a fearful child, but one incessantly and excessively worried by this fear. In

time the fear extended to other objects. Through the laws of association her impulse of fear attached itself to similar objects and she soon showed something approaching general fear of losing her possessions—this fear extended to one entire class of objects—those things handled and from time to time laid aside. She had no fear of animals, rough playmates or the forces of nature. Fears such as hers are developed through suggestion.

A teacher recognising that fears are acquired and frequently in pre-school days, uses all corrective and remedial measures. She tries to anticipate and prevent them.

"Fear," of course, is far too big a topic to do more than touch on here.

In the January, 1928, issue of *Mental Hygiene*, there is an article on "School Room Hazards to the Mental Health of Children." The opening statement is "not all is well with the school child of today. There are hazards that threaten his mental health, and these hazards are certainly on the increase." The writer regards speed as one of the greatest of the hazards. The school supervisors require speed of teachers, and they in turn hold the stop watch, so to speak, on the child. Educators have assumed that the way to speed in performance of school work is to force the pupil to hurry—he must learn certain things by a certain date—and the child who can't learn fast is decidedly out of luck. A great many times the nervous system of both child and teacher cracks under the strain. The aim, of course, is to standardise the best in good teaching, and to help the teacher, but in practice their efforts do more harm than good. One reason children work so slowly is because we try to make them work so fast. If emphasis is put upon accuracy, and the learner has a comfortable atmosphere to work in, speed is sure to follow.

Probably you feel there is over much about the teacher and very little about the nurse so far; but in considering this question, the teacher, who has the oversight of the child

for so many hours of the day, is bound to play a prominent part. However, the school nurse has her role, and an important one too. She is the link between the home and school. She has the entree to the home, and can by her tact and insight, bring to the parents understanding of the child's problems and help smooth out many wrinkles. She interprets the home to the school and the school to the home, so that there may be harmony and co-operation instead of misunderstanding and conflict. Parents are so prone to blame the teacher if a child does not progress; in a few cases this blame may be deserved, but more often it is not, and parents certainly do not help matters by audibly and visibly siding with their child, fostering this idea in their mind instead of trying to get to the bottom of the trouble, facing the facts and helping to surmount them.

There are a few things to keep in mind when dealing with children. They are everyday common sense things—we all know them and practice them—when we don't forget.

1. Never tell a child he is nervous, delicate or temperamental. Just what constitutes a "nervous child" no one seems quite sure, although one hears of them daily—the best medical science of today denies the existence of such a child, but it does find that the so-called nervous child is usually the victim of parental ambitions or oversolicitude or unwholesome stimulations of family environment and struggle to keep up with the Joneses.

2. Don't discuss your own or other people's pains, aches or pet ailments in a child's hearing. They are bound to copy and use them as an excuse for avoiding to do things they don't like.

3. If a child habitually sulks or pouts don't argue or punish, or scold or try to divert his attention through bribery. Such tactics only direct attention and consideration to him, which is what he wants. Ignore him absolutely until he snaps out of it.

4. Never make a promise to a child which you have no intention of keeping, whether the promise be a punishment or a treat, make good your promise.

5. As a child grows older and asks reasons for this or that, give him a frank and direct answer, but don't argue for argument's sake.

6. Don't nag a child to sit still, stop wiggling or what not. A child can't sit still long, and if he has something to do, he will be too busy to wiggle or sniff or otherwise annoy.

7. Before giving a child a command, first make sure you have his attention—if he is playing hard very often it doesn't really penetrate. But once sure you have his attention, see that the child obeys then and there. He soon learns you mean business when you speak.

8. Don't try to do a child's thinking for him, or to make all his decisions, but rather help him to learn independence and to meet difficulties squarely, to repress undesirable tendencies. Repression of a certain kind is something we all have to learn as part of our development as social beings.

10. Always remember a child is an individual with rights which must be respected, but he must be taught in exchange to learn respect for the rights of others and the authority of those over him.

In the Division of Mental Hygiene, in the Department of Health, to which I belong, we see a great many children in the course of a year, and they are of all ages and sorts, with many varieties of difficulties. During the first few years we were, unfortunately, forced by circumstances to confine our efforts almost entirely to dealing with the feeble-minded and much retarded child. This gave most people the idea that "mental hygiene" covered only this type of work, rather than it meant preventive work. Many got the notion firmly planted in their minds that a psychometric test carried the so-called stigma of mental deficiency, and so many urgent cases were not presented. However, this attitude has

been surely, if slowly, overcome, and now we get an overgrowing percentage of children with behaviour difficulties and what-not, as well as those who are not progressing. Many parents now seek advice of their own accord and accompany their child on his visit to the psychiatrist so they can talk over the trouble. They show a genuine desire to learn what is wrong, and to do their part in solving the

problem. When necessary our psychiatric children's worker takes over the case for intensive and highly specialised work for a period before handing it over to the school nurse who could not devote the same amount of time and study to it.

Altogether the outlook in Toronto, at least, seems more hopeful now than ever before.

## *Mental Health in the Nursery School*

By JOYCE DAVIDSON, Reg.N., Department of Public Health, Toronto

One frequently hears it said that too much stress is now being laid upon the education of the pre-school child: that the nursery school is too much of an innovation, and too experimental at the present stage. But surely all education is, or should be, experimental to some extent. And as to its being an innovation, let me quote from Professor Lodge's recent work on Plato. He describes Plato as beginning his outline of education with a discussion of pre-natal conditions, going on to emphasise the kind of treatment required by a child during the first three years of his life and stating that "the tendency to cry whenever a child is afraid or wants anything, may easily, if unchecked, lay the physical foundation for dispositions, which if further developed will become the vicious habits of excessive timidity, garrulousness and bad temper."

The nursery school movement proper began in England with community service as its basic ideal. In the United States the research side was stressed, and the present trend in Canada is towards a combination of these objectives. We believe that by endeavouring to develop and foster in little children those characteristics which will help them to become successful members of the society to which they belong, we are laying the foundation for an improved community life in the future. In the present, we are providing a stage-setting, suitable to meet the growing child's need for both mental and

physical development. Growth is a dynamic process and its evaluation in terms of what it brings of satisfaction and fulfillment to the individual growing must be repeatedly emphasised. Education has not yet quite outgrown the point of view that the function of the school is primarily to prepare children for a future in which the activities made possible for them should have value in adult terms. In other words, it has been looking for a product that would be valuable not primarily to the child in the process but to society in its final stage.

Let us divide our subject into three parts in order that we may be quite clear as to exactly what it is that we are trying to do:—

1st—Child Study.

2nd—Parent Education.

3rd—Child Training.

1. CHILD STUDY: The nursery school is used partly as a laboratory, affording scientific and trained workers an opportunity of observing children in a controlled environment as nearly as possible approaching the ideal. The children are observed, not in any artificial or distorted situation but in the normal routine of playing, eating and sleeping.

2. PARENT EDUCATION: The programme for parent education might be divided into two parts—(a) Study Groups, and (b) Demonstration.

(a) As a means of leading parents to a better understanding of child behaviour, the results of studies made in the nursery school and any accepted ideas of training based thereon

are presented to the mothers at study groups or classes. These classes afford an opportunity for discussion and exchange of theoretical and practical methods being used by the mothers themselves.

(b) By using the nursery school as a demonstration centre where the mothers may see with their own eyes and be convinced, in order that they may carry into their homes the practical methods they have witnessed. To quote Winifred Rand, "the parents may, in the nursery school, see children freed for self-expression and yet learning self-control; freed for self-development, yet learning self-responsibility; respected as individuals, and yet learning to respect the rights of others. And the parents, seeing these things learn that the child at home may, much more often than they have thought, have the opportunity of choice, go through days with much less direction and may be counted upon to do much more for himself than they had thought possible. They also see methods practised successfully which had not occurred to them as practical or feasible, and they begin to understand that back of these methods are underlying principles which can be the basis for their own practice at home.

3. CHILD TRAINING: In the nursery school, this living and learning place, the child's physical well-being receives the same care and consideration that is given his social, mental and emotional well-being. *Mens sana in corpore sano* is the motto, and we find that mental superiority is far more likely to be healthy and stable if accompanied by physical health. So, a sound body, happily habituated to a healthful routine is of the utmost importance. A race of children with such a start in life should make impossible an army of neurotic adults, crystallised into habits of unhealthful eating, drinking and sleeping with all their accompanying ills; and time therefore spent worrying about symptoms and treatments would be freed for more constructive purposes.

In an adult environment such as the ordinary home, the physical, social and

economic environment surrounding children is administered by beings whose background, interests and standards of conduct are totally foreign to those of children. The nursery school is an attempt to scale civilization down to the child level in its behaviour demands, and to open up wider opportunities for active exploration than an adult world can afford. Here we have toys on shelves easily within reach of small hands and equally easy to replace when play-time is over, toilets, basins and taps are likewise suitable in size for little people to use, and tables and chairs are made so that they can sit with their feet comfortably on the floor. In learning to eat and drink after the manner approved by society it is probable that milk and food of various sorts will sometimes be spilled and this is considered in the choosing of the floor-covering for the room that is to be used as a dining room. In this way the nervous tension frequently seen at meal times and partly caused by fear of the spoiling of a good rug is obviated, and the child has an opportunity to learn to eat acceptably in a place where he himself can quite easily get a cloth and wipe up anything that may, inadvertently, be spilled. In choosing all our materials for work and for play we try to avoid those that prove to require in their use adult supervision beyond what is needed to safeguard a child's initiation to them.

So we see that the aim and object of all workers in nursery schools, be they parents, nurses or teachers is one—the mental health of the child. And this, as Dr. Blanton says "is no God-given faculty. It is the successful adjustment of the individual to his environment . . . and successful adjustment is not taught by word of mouth but by the logic of the situation. Adjustment is pragmatic; if a thing works it becomes incorporated in the being who worked it. If it is socially acceptable in the broad sense, the result is good mental health; if it can not be tolerated by society it is bad mental health." . . . And such education must begin at birth.



## Public Health

During the annual meeting of the Canadian Medical Association, held in Montreal, June 18-22, 1929, the Public Health Section of that Association held a number of joint meetings with the Canadian Public Health Association and the Canadian Social Hygiene Council, both of which held annual meetings during the same week.

Headquarters for these three Associations were at the Windsor Hotel, where there was also a most attractive exhibit.

The sessions which were well attended dealt with many public health and social hygiene problems and questions. As one followed each session it was realised that in all parts of Canada, medical men and nurses are actively engaged in promoting the development of health, hygiene and sanitation; as well as devising means by which the public, singly and in groups, may become interested in and better understand these subjects as they affect themselves.

The Public Health Nursing Section held one session at which the chairman, Miss Edith B. Hurley, of Montreal, presided. Subjects presented at this session were: "The Problem of Securing Recruits for the Public Health Nursing Field," by Miss Elizabeth L. Smellie, Chief Superintendent Victorian Order of Nurses for Canada; "Some Aspects of Industrial Nursing," by Miss Dorothea MacDermot, Industrial Nurse in charge of the Health Department of the National Breweries Limited, Montreal; and "The Public Health Nurses of the Division of the Hygiene of Infancy, Public Health Department of Montreal," by Miss Marie Roy, nurse in charge of the Division of the Hygiene of Infancy, Public Health Department, of Montreal.

An interesting discussion followed, which was led by Miss Blanche Lecompte, Nurse in Charge of the Health Department of the Frontenac Breweries, Montreal.

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## Nurses' Bulletin

Just recently three copies of the Public Health Nurses' Bulletin, issued yearly by the Provincial Board of Health of British Columbia, have come into my hands. From Dr. H. E. Young, their Provincial Health officer, we learn that contributions come from any or all of their fifty-one nurses. That they are expressions of the nurses' own enthusiasm and progressive view-points, the reader appreciates for herself.

The editorial in the April, 1929, number presents the need for that "mental fitness" for the pioneer nurse which avoids a feeling of isolation and intellectual loneliness. Judging from the articles read we would surmise that the organisation in British Columbia has been planned to that end, and their nurses, with widely diverse

fields of activity, are able to maintain a community of interest.

In the field of analysis we read articles discussing the value of group health teaching, community attitudes to curative as against public health service, or others evaluating the results of school nursing. In the field of development and progress one reads articles about spade work being done in a pioneer district, the organisation of a piece of public health work in a rural district, and so on.

A bulletin of this character must have, in addition to the binding together of the interests of the workers, a future historical value. To those of us outside the province the development of the work is of great interest, and of certain value in its possible application to our own field.

# News Notes

## ALBERTA

UNIVERSITY OF ALBERTA HOSPITAL, EDMONTON: Miss Alice Mary Olds (Toronto General Hospital), has accepted a position on the staff.

CALCARY: Misses E. McPhedran, S. MacDonald, H. Ash, G. Hill, L. Peat, M. Lovell and J. McGowan are among the nurses who attended the International Congress of Nurses in Montreal.

## NEW BRUNSWICK

The annual meeting of the New Brunswick Association of Registered Nurses will be held in Saint John, on September 17th and 18th, 1929.

SAINT JOHN: A committee of the Saint John Chapter of Registered Nurses held a most successful bridge at the residence of Mrs. F. W. Barnhill; the proceeds of which are to increase the Stammers Memorial Fund for the purpose of furnishing a ward for boys in the new General Hospital.

GENERAL PUBLIC HOSPITAL, SAINT JOHN: Miss Margaret Murdoch, superintendent of nurses, is spending her vacation in Toronto, and will also attend the International Congress of Nurses at Montreal.

Miss Sidonna Wetmore (1927), has accepted a position on the staff of the Victoria Hospital, Fredericton, N.B.

SOLDIERS MEMORIAL HOSPITAL, CAMPBELLTON: Graduating exercises were held in the High School, June 11th, six nurses graduating. The large number of friends and relatives very much enjoyed the splendid address given by Dr. W. W. Chipman, of Montreal. A violin solo by Miss Ruth Anslow, and a vocal solo by Mrs. W. A. Fitch added greatly to the programme.

On June 10th the graduating class was entertained at a most enjoyable dinner given by the Alumnae.

## NOVA SCOTIA

HALIFAX: The annual meeting of the Halifax branch of the Registered Nurses Association was held at the Dalhousie Public Health Clinic, June 25th, 1929. Following the business meeting, Miss Gladys Strum, president, gave a very interesting talk on her recent visit to the various hospitals and clinics in the United States, made possible by a Rockefeller Fellowship.

Miss Eileen Boland sailed on the "Nova Scotia," June 29th, for her home in Ireland.

Miss Eulah Armstrong, of Sydney, graduate of the New England Hospital, Boston, is spending the summer at her home.

Miss Helen Hoyt, of Middleton, graduate of the Rhode Island Hospital, Providence, R.I., is visiting at her home.

Miss Mary MacGillivray, of Antigonish, has accepted a position on the staff of the Carney Hospital, South Boston, Mass.

The sincere sympathy of many friends is extended to Miss Catherine MacDonald, Bridgeport, in the great loss of her mother, Mrs. Neil MacDonald; and to Miss Claire Otto, Dartmouth, in the death of her father, Mr. Pius Otto.

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in July, 1929, were 1,203. Forty-one more than previous month.

### APPOINTMENTS

Miss Beulah Burleigh (Kingston General Hospital, 1921), to the staff of the Kingston Penitentiary.

Miss Mary Turner, who has recently completed a course as instructor at the School for Graduate Nurses, McGill University, has been appointed instructor at the University Hospital, Edmonton.

Miss Kathleen Frizelle (Ottawa Civic Hospital, 1929), to the staff of the Shriners Hospital, Montreal.

Misses Marion Lavis, Mabel Casselman, Alma McLeod, Jean Craig (Ottawa Civic Hospital, 1923), to the staff of the Anson General Hospital, Iroquois Falls, Ont.

### DISTRICT 1

PUBLIC GENERAL HOSPITAL, CHATHAM: The annual commencement exercises of the Training School were held on June 4th, when nine nurses received their diplomas.

Miss Florence Emory, Assistant Director of Public Health Nursing, University of Toronto, delivered a very delightful address stressing the importance and benefits to the graduate nurse of active membership in the Alumnae Association of her own school and the Registered Nurses Association of Ontario. After the exercises the nurses and their friends were entertained at a reception and dance held in the Nurses Residence.

Among those to attend the International Congress in Montreal from Chatham were Misses P. Campbell, F. Murray, G. McKerracher, Amy Coll, Mima Coll, Edna Orr, and Annie Head.

### DISTRICT 2

The quarterly meeting was held at the General and Marine Hospital, Owen Sound, and was well attended, a large number motoring from Brantford, Simcoe and Galt.

Miss Buck, president, was in the chair. An interesting report of the Kingston Convention was read by Miss Jamieson, superintendent, Galt General Hospital. A letter of introduction for the discussion of group nursing at the October meeting which will be held in Kitchener, was given by Miss J. Davidson.

**GENERAL HOSPITAL, BRANTFORD:** The graduating exercises took place in the Collegiate Institute on June 19th, nineteen students graduating, all with first class honours.

A delightful dinner-dance was held June 12th at the Brantford Golf and Country Club by the Alumnae, in honour of the graduates. An interesting toast list was a feature of the affair. Roll call was responded to by greetings to the 1929 graduates and by a member of each class since 1913. Following the dinner the remainder of the evening was spent in dancing.

The annual meeting of the Alumnae was held June 13th, in the Nurses Residence with thirty-six members in attendance. The officers for the ensuing year were elected. It is interesting to note that the membership has doubled during the last year due to the efforts of Miss Helen Potts. A very interesting illustrated address on the History of Nursing was given by Dr. J. E. Carson.

On June 18th, there was a happy gathering at a dinner given by the staff in honour of Miss K. Haycocks, who is retiring after twelve years faithful service. She was presented with a beautiful travelling clock, and an illuminated address. A presentation of a bag was made to Miss Mary Wilson, who has been supplying for the past year. A miscellaneous shower was also tendered Miss K. Charnley on leaving for a three months' trip to Europe. After dinner a motor drive and theatre party brought a greatly enjoyed evening to a close.

#### DISTRICT 4

**GENERAL HOSPITAL, HAMILTON:** The annual dinner of the Alumnae given in honour of the graduating class of 1929, took place in the Royal Connaught Hotel on May 31st, and proved to be a most delightful affair. Miss Cora Taylor, president, welcomed the new graduates and voiced the hope that they would all become loyal and faithful members of the association. Mr. Roy Fenwick conducted the community singing and Miss C. Currah contributed vocal solos which were enthusiastically encored. Miss Rayside spoke briefly, directing her remarks to the graduating class and announced the names of those who had won prizes and scholarships for the year.

Rev. Wm. Barclay, the special speaker for the occasion, laid emphasis on the value of the discipline of nursing, and extended his sincere good wishes to members of the class stating that no other profession for women stands so high.

Miss Muriel Booker (1922), is on the staff at Sea View Hospital, Staten Island, N.Y.

Miss Ivy Bannister (1922), is in Long Island, N.Y.

Miss Margery Baxter (1922), is in Buffalo, N.Y.

Miss Ketchen has gone to make her home with a sister in Cambridge, Mass.

On May 11th, the Mutual Benefit Associa-

tion held a bridge which netted about \$50.00 for the Association.

**St. JOSEPH'S HOSPITAL, HAMILTON:** The graduating exercises were held at the Nurses Residence on May 11th, at which sixteen nurses graduated. Addresses were given by Right Rev. Msgr. F. F. Blair and Mayor Burton.

**GENERAL HOSPITAL, St. CATHARINES:** Colonel and Mrs. R. W. Leonard have given a scholarship again this year to a graduate of the Hospital for a year's course at the University of Toronto, in Public Health Nursing. The award was made to Miss Esther Hanna, of Kirkton, Ontario, who has been night supervisor since Feb., 1928.

#### DISTRICT 5

**CONNAUGHT TRAINING SCHOOL FOR NURSES, WESTON:** The annual meeting of the Alumnae was held at the Toronto Hospital, at Weston, on June 7th. The officers for the year 1928-1929 were re-elected by acclamation for the year 1929-1930, and are as follows: Honorary president, Miss E. MacPherson Dickson; president, Miss L. M. Smith; vice-president, Miss E. Robertson; secretary, Miss Ruth MacKay; treasurer, Miss Clara Foy.

**St. MICHAEL'S HOSPITAL, TORONTO:** The Alumnae held an enjoyable reception on June 29th in honour of the graduating class and also to celebrate the twenty-fifth anniversary of the association. Miss Essie Taylor, the president, the sister superior, and the superintendent of nurses received the guests. Flower-decked tables and an orchestra added to the pleasure of the occasion. The graduates were received into the Alumnae, and this was followed by an entertainment.

**GENERAL AND MARINE HOSPITAL, COL- LINGWOOD:** The annual meeting of the Alumnae was held May 31st. Election of officers for the ensuing year are: President, Miss M. Geddes; vice-president, Mrs. Wm. Hicks; secretary, Mrs. Chester Lee; treasurer, Mrs. C. Agnew.

The official opening of the new McCarthy Memorial wing was held May 11th. Mr. Leighton McCarthy, the donor, unveiled the tablet and made the formal presentation. A number of short addresses followed. Tea was served in the Nurses Residence.

**GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO:** On May 21st, the graduating exercises took place of the 1929 class of the hospital. Prizes were given to: Miss Ida Weeks, gold medal for highest standing in examinations and general proficiency, also Miss Coulter's prize for highest standing in dietetics; Miss Helen MacPherson, gold piece for second highest standing in examinations; Miss Mary McCullough, gold piece for third highest standing in examinations; Miss Evelyn Stinton, Mrs. Hamilton's prize for neatness and general proficiency. The other graduates were: Misses Rhoda Irene Law, Christena McCallum, Dorothy Hay Hartley, Mary Margaret McDonald, Sadie Templeton McLaren, Mary Isabel Lucas, Marjorie Suzanne Mor-

gan, Florence Marguerite Hamilton, Frances Victoria Fawley, Ella Mildred Gordon, Evelyn Eileen Osterhout.

This was followed by a reception and dance in the drawing room of the hospital.

#### DISTRICT 7

**GENERAL HOSPITAL, KINGSTON:** The Alumnae held its last meeting for the summer on June 12th. After a short business meeting, a social evening was spent. The members of the recent graduating class were guests of honour.

Miss Irene Breckenridge (1928), is on duty at the Eastern General Hospital, Toronto.

Miss Miriam Michell (1926), has returned to Ann Arbor, Mich., where she has a position in the University Hospital.

Misses Thelda McAdoo (1922), Aletha Hatton and Gertrude Palmer (1929), are doing general duty at the Nyack Hospital, Nyack, N.Y.

Miss Viola Boulette (1929), is doing general duty at the Eastern General Hospital, Toronto.

Miss Mabel Bonter, on the staff of the Hospital, who has been seriously ill with pneumonia, is now convalescing at her home in Trenton, Ont.

Miss Inez Stoodley (1926), is on duty at St. Luke's Hospital, New York City.

#### DISTRICT 8

**OTTAWA:** To Ottawa nurses was accorded the great honour of being hostesses to the members of the Grand Council of the I.C.N. on the occasion of their brief visit to Ottawa on July 3rd.

Arriving by special train from Montreal at noon the visitors were met by a large number of Ottawa nurses, and after they had been welcomed by the civic authorities in the rotunda of the station, all proceeded to the Parliament Buildings where official welcome on behalf of Canada was extended by the Right Honourable W. L. McKenzie King, Prime Minister. Present also on the Hill to join in greeting the nurses were official representatives of the various embassies and consulates, together with heads of national women's organisations.

A brief tour of the buildings then took place, after which the distinguished visitors were guests of the Right Honourable George P. Graham, president of the Victorian Order of Nurses for Canada, and Mrs. Graham, at the Country Club.

In the afternoon a drive around the city was conducted by the members of the medical profession of Ottawa. The visiting nurses were entertained at tea by Sir William Clark, High Commissioner for the United Kingdom, and Lady Clark, the Hon. Wm. Phillips, Minister for the United States, and Mrs. Phillips, the Hon. Jean Knight, Minister for France, and Mr. Li Tchuin, Counsel-General for China.

A banquet at the Chateau Laurier, given by the graduate nurses of Ottawa concluded the day's programme. Miss Garvin, chairman of District No. 8, in her address

of welcome referred to the pleasure it gave Ottawa nurses to entertain for even so brief a time their distinguished sisters in the profession. Miss Garvin paid tribute to the memory of Baroness Mannerheim, Sister Agnes Karll, and Miss Flora Madeleine Shaw, great leaders of the profession who have passed on since the last meeting of the Congress in Finland.

Greetings were conveyed to the visitors in French by Miss Robert, assistant night supervisor of the Ottawa General Hospital, and in German by Miss Marjorie Robertson (Toronto General Hospital, 1923), of the staff of the Royal Ottawa Sanatorium.

Miss Hersey, president of the C.N.A., spoke briefly. Miss Nina Gage, president of the I.C.N., after replying to the addresses of welcome conducted a roll call by countries.

The visitors received a rousing send-off by Ottawa nurses as their special train pulled out at 9.00 o'clock. The day, though short, had been one of great pleasure and profit to those fortunate enough to be hostesses on this occasion.

**CIVIC HOSPITAL, OTTAWA:** Miss Lera Berry (1927), is substituting on the third floor for the summer.

Miss Ina Woods, night supervisor of the Maternity Floor has left for a trip to Europe accompanied by Miss Lois Aylen (1926).

**LADY STANLEY INSTITUTE:** A special meeting of the Alumnae was held on June 10th at the home of Miss Mary Slinn. Arrangements for the entertainment of the Grand Council of the International Council of Nurses on July 3rd were discussed.

#### DISTRICT 10

The monthly meeting of District No. 10 was held on June 6th, in the Nurses Home of the McKellar-General Hospital, Fort William. The speaker of the evening, Mr. J. J. Flanagan gave a very interesting talk on California. Mrs. McGowen's beautiful singing was much enjoyed by her audience. The meeting adjourned until the second Thursday in September. Refreshments were served by the McKellar nursing staff.

On May 31st, the Thunder Bay Medical Society, of Fort William, entertained two very distinguished European physicians, Dr. G. B. Roatta, of Florence, Italy, and Dr. Delille, of Paris, France. At the McKellar Hospital, Dr. Delille lectured upon the prophylactic treatment of infants. Dr. Roatta's lecture at St. Joseph's Hospital, Port Arthur, was upon tuberculosis.

Included in the list of the seven graduates who achieved scholarships and prizes at the Winnipeg General Hospital graduation, were Misses Dorothy E. C. Mathias and Elizabeth J. Byers, of Fort William. Miss Mathias won first prize presented by Mr. E. D. Martin for theoretical work, and Miss Byers for practical work, presented by the Alumnae Association. Miss Phyllis R. Webster, Fort William, and Miss Lila Ruth Miller, of Port Arthur, were also among the list of new graduates.



Miss Christine McLeod returned to New York last week after visiting her sister, Mrs. Hugh Lowrie, of Fort William. Miss McLeod also attended the graduation of her sister, Miss Jessie McLeod at the Winnipeg General Hospital.

**McKELLAR-GENERAL HOSPITAL, FORT WILLIAM:** At the May meeting of the Alumnae, Miss Gerry read a splendid paper on Highland Hospital, Rochester, written by Miss B. Montpettit.

The meeting of the alumnae was held on June 25th. After a short business session, the meeting adjourned. The hostesses for the occasion were Miss Pearl L. Morrison, superintendent of the hospital and her 1929 graduating class. During the evening a presentation was made on behalf of the Alumnae by Miss Jane Hogarth to Miss Mabel Mitchell, who leaves shortly for Winnipeg and Detroit.

**ST. JOSEPH'S HOSPITAL, PORT ARTHUR:** On June 19th, 1929, the graduation exercises were held in the Winter Garden. The chairman for the occasion was Dr. Chas. Powell, who gave a fine invigorating speech outlining the progress of the hospital, which had grown from a very small one to its present size of 130 beds. Rev. Father Primeau presented the medals and diplomas to the following new graduates: Misses C. Rummery, E. Sauriol, B. Cuthbertson, L. Pettit, B. Atkinson, D. Flummerton, K. Rosie and R. Haglund.

Special prizes were awarded to Miss Rosie for faithfulness to duty; to Miss Sauriol for highest marks in medicine; to Miss Haglund, highest in Pediatrics, and to Miss Hamilton, highest in second year nursing. Thermometers were presented to each nurse by the ladies of the Hospital Aid. Dr. G. E. Eakins awarded the Medical Staff Medal to Miss Laverne Pettit.

### PRINCE EDWARD ISLAND

The annual meeting of the Graduate Nurses Association was held on June 11th at the Queen Hotel, Charlottetown. Twenty-four members were present. Officers elected for the coming year are: President, Miss King; vice-president, Mrs. P. Proud; secretary-treasurer, Miss A. Mair; convener, Public Health, Miss M. Wilson; convener, Nursing Education, Sister Faustina; convener, Private Duty, Miss M. R. Gamble.

The registration fee was raised to \$5.00 and the annual membership fee to \$2.00. It was also decided that all nurses not registered in this province and desiring to practise here, be asked to pay a registration fee of \$5.00.

Ten nurses who graduated last year received their R.N. certificates.

An appeal was made for subscriptions to The Canadian Nurse.

After the meeting, a delightful dinner was served, at which the graduating class of the Prince Edward Island Hospital were guests.

**PRINCE EDWARD ISLAND HOSPITAL, CHARLOTTETOWN:** The graduating exercises of the 1929 class were held in St. Paul's Parish Hall, Charlottetown, on May 14th. Ten nurses

received their diplomas. The address to the graduates was given by Dr. Yeo, and the diplomas were presented by His Honour, Lieutenant-Governor Heartz. A very pleasant programme was arranged by the Ladies' Aid of the hospital, who also presented each graduate with a beautiful bouquet of flowers. Later the graduating class were guests at an informal reception at the Nurses Home.

On May 24th, the graduating class were guests at a dance given by the medical and nursing staff at the Navy League Building.

### QUEBEC

**SHERBROOKE HOSPITAL:** The monthly meeting of the Graduate Nurses Association was held June 13th, at the home of Miss Margaret Robins. Means of raising money for maternity cases was discussed; also reference was made to an increase in fees. At the close, refreshments were served.

The very delightful garden party at the residence of Mrs. Stevens given by the association was in every way a huge success. Miss Doris Stevens, president of the associations, Miss Helen Buck, superintendent of the hospital and Mrs. Stevens received the guests. The proceeds, which were very gratifying, will be devoted to a special fund for a nurses' memorial to be placed in the McKinnon Memorial Building in honour of the late Mrs. G. McKinnon, who always took an active interest in the association and was one time a president. The nurses are very grateful to Mrs. Stevens for so generously putting her home and grounds at their disposal.

Miss Charland has resigned her position as Instructress to the nurses. We all regret her departure.

Miss Gladys Van has been visiting Mrs. Jack Watson, Lennoxville, P.Q. Miss Van does private duty nursing in Montreal.

The sympathy of the association is extended to Miss Helen Hetherington in the loss of her father.

**ROYAL VICTORIA HOSPITAL, MONTREAL:** Miss Kathleen I. Sanderson has accepted an appointment on the staff of the Canadian National Institute for the Blind, as Field Worker in the Western Division.

### SASKATCHEWAN

**CITY HOSPITAL, SASKATOON:** Miss Margaret Robb (1928), has left for Rochester, Minn., and will do special duty work in St. Mary's Hospital.

Miss Verena McIvor has returned from New York, where she spent six months on the staff of the Dobb's Ferry Hospital.

Mrs. W. J. Pulley (Elsie Maloney, 1917) and two sons, Bob and Jack, are spending the holiday at the Pacific Coast.

Miss Irene Bowron (1926) is taking a course in X-ray and physio-therapy at the Hospital.

We are sorry to hear of the serious illness of Miss Helen Simm, (1923), in the Shaunavon Hospital. Miss Simm has held a position in the Shaunavon Hospital for some time.

## BIRTHS, MARRIAGES, AND DEATHS

## BIRTHS

- CLARK—On May 30, 1929, at Kingston, to Dr. and Mrs. A. Clark (Miranda McMonagle, Kingston General Hospital, 1923), a son (Donald McCoy).
- CLARKE—On June 14, 1929, at Jamaica, Long Island, to Mr. and Mrs. Edward J. Clarke (Evelyn Arguin, Sherbrooke Hospital), a daughter.
- DAVIS—On May 8, 1929, at Ottawa, to Mr. and Mrs. Jas. Davis (Mary Jane Butler, Ottawa General Hospital, 1924), a son (John James Merrill).
- FITZSIMMONS—Recently, at Ottawa, to Mr. and Mrs. Fitzsimmons (Betty Brown, Lady Stanley Institute, 1924), a daughter.
- HOWES—Recently, at Kingston, to Mr. and Mrs. Joseph Howes (Mary Keon, Hotel Dieu Hospital, Kingston, 1920), a daughter.
- LARUE—On January 21, 1929, at Tsunyi, Kweichow, China, to Mr. and Mrs. LaRue (Dorothy French, Hamilton General Hospital, 1923), a son (Gerald William).
- MEREDITH—Recently, at Ottawa, to Mr. and Mrs. Cecil Meredith (Helen Hudson, Ottawa Civic Hospital, 1928), a son.
- McKAY—On April 14, 1929, at Kingston, to Mr. and Mrs. Lionel McKay (Gert-rude Fitzsimmons, Kingston General Hospital, 1923), a son (Terrence Lionel).
- WARD—On June 8, 1929, at San Francisco, California, to Mr. and Mrs. William Ward (Bertha Dowsett, Saskatoon City Hospital, 1926), a son.
- WATSON—On May 9, 1929, at Melfort, Sask., to Mr. and Mrs. George Watson (Sadie McEown, Saskatoon City Hospital, 1917), a son.
- YOUNG—Recently, at Ottawa, to Mr. and Mrs. Young (Marie Casselman, Ottawa Civic Hospital, 1926), a son.

## MARRIAGES

- BONNER—ROBBINS—Recently, in June, 1929, Mary Agnes Robbins, Truro, N.S., to John T. Bonner, of Antigonish, N.S.
- CAMPBELL—MOULAND—On June 18, 1929, Mrs. Fern Moulant (Fern Hamilton, Saskatoon City Hospital, 1921), to A. E. Campbell, of Saskatoon, Sask.
- CORNELL—WILSON—On June 4, 1929, at Dafoe, Sask., Lilian Wilson (Saskatoon City Hospital, 1926), to Howard Cornell, Domremy, Sask.
- DOLERY—BONSER—Recently, at Calgary, Alta., Marie Audrey Bonser (Holy Cross Hospital, Calgary, 1927), to Joseph J. Dolery, M.D., of Gadsley, Alta.
- FOSTER—SMITH—In June, 1929, at Saint John, N.B., Hazel Henrietta Smith (General Public Hospital, Saint John, 1927), to George Joel Foster. At home, Saint John.

- MILNE—SWAYZE—On June 22, 1929, Evelyn Swayze (Hamilton General Hospital, 1923), to Robert E. A. Milne, M.D.
- MURPHY—SHAW—On May 18, 1929, at Ottawa, Elizabeth Shaw (Ottawa General Hospital), to John Murphy.
- NORRIS—FOLEY—On June 15, 1929, at Peterborough, Ont., Mary E. Foley (Hotel Dieu Hospital, Kingston, 1926), to Frank Norris, of Kingston. At home, Montreal, P.Q.
- OLDENBURG—BANKS—On June 23, 1929, at Reno, Nevada, Mabelle Gene Banks, of Caledonia, N.S., to Ray William Oldenburg, M.D., of Colorado. At home, Klamath Falls, Oregon.
- RACINE—QUINN—Recently, at Ottawa, Alma Quinn (Ottawa General Hospital), to Horace Racine, of Ottawa.
- SCHMIDLIN—JAKES—On June 2, 1929, Esther Jakes (Ottawa Civic Hospital, 1927), to Frank Schmidlin, Phm.B.
- SIMPSON—COOLEN—On June 5, 1929, at Dartmouth, N.S., Mary Ellen Coolen (Nova Scotia Hospital), to Major William Duff Simpson, R.C.E. At home, Halifax, N.S.
- SUTHERLAND—CRAWFORD—In June, 1929, at Amherst, N.S., Gwendolyn Crawford, of Amherst, to J. W. Sutherland, M.D.
- SWITZER—CURRIE—On June 5, 1929, Janet Currie (Collingwood General and Marine Hospital, 1925), to William Albert Switzer, of Collingwood. At home, Collingwood, Ont.
- WALKER—BATTEY—On June 13, 1929, Freda Battey (Winnipeg General Hospital, 1926), to Rev. Remington Walker, of Kerrobert, Saskatchewan.
- WATSON—WALKER—On June 4, 1929, at Edmonton, Alberta, Doris E. Walker (Royal Alexandra Hospital, Edmonton, 1927), to Stanley H. Watson.
- WILSON—SMITH—Recently, Marie Smith (Ottawa Civic Hospital, 1925), to Asa Wilson.

## DEATHS

- BABCOCK—On May 23, 1929, at Harrowsmith, Ont., Eva Babcock (Kingston General Hospital, 1927).
- BALLANTYNE—On May 6, 1929, at Ottawa, Mrs. C. T. Ballantyne (Elizabeth Ritchie, Lady Stanley Institute).
- GREEN—On March 5, 1929, at Kingston, Nursing Sister Annie Green (Kingston General Hospital, 1909). Interment at Sonerton, Ontario.
- JEFFERSON—On June 4, 1929, at Ottawa, Mrs. Robert Jefferson (Edith Strong, Lady Stanley Institute).
- POTTS—On June 10, 1929, at Ottawa, Mrs. J. MacLaren Potts (Emily Harper, Lady Stanley Institute).

## Victorian Order Supervisors Demonstrate to McGill Students

By M. L. MOAG, District Superintendent, Victorian Order of Nurses, Montreal

At the request of the Director of the Department of Public Health and Preventive Medicine of McGill University, the Montreal Victorian Order of Nurses recently demonstrated to the third year medical students the visit of a public health nurse in the home. The class was divided into two groups as it was felt the entire class was too large for such an intensive demonstration.

Miss M. L. Moag, district superintendent, gave a brief outline of the policies and scope of the organization in the local district as well as throughout Canada.

Miss Marion Nash, teaching supervisor, and Miss Isabel Manson, assistant supervisor, demonstrated the actual procedure of a nursing visit to a maternity case, enlarging upon the opportunity for teaching in the

home, referring particularly to the scope of the pre-natal work. Emphasis was laid upon the necessity and value of more intensive supervision of the expectant mother.

The students listened very attentively and at the conclusion of the demonstration had very many questions to ask: questions which covered every phase of the demonstration from the equipment of the nurse's bag, the cost of the baby's basket, and the subject matter of teaching, to the administration of the nurses' time and salaries.

As a result of this demonstration it is felt that the Order has awakened an interest in the minds of these coming physicians that should have a far-reaching effect upon the V.O.N. and its work in the future.

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### THE CANADIAN NURSE

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## SEPTEMBER, 1929

	PAGE
THE CONGRESS - - - - -	451
EXHIBITS (ILLUSTRATED) - - - - -	479
PRESIDENT'S ADDRESS - - - - -	<i>Nina D. Gage</i> 486
THE WATCHWORD: "SERVICE" - - - - -	<i>Ethel G. Fenwick</i> 490
THE FUTURE - - - - -	<i>Adelaide Nutting</i> 492
THE SCIENTIFIC METHOD IN SOCIAL AND HEALTH WORK - - - - -	<i>Julius Tandler</i> 498
THE NURSE AS A CITIZEN - - - - -	<i>Bertha Wellin</i> 505
EXCHANGE SCHOLARSHIPS - - - - -	<i>Alice Lloyd Still</i> 509
UNIVERSITY SCHOOLS OF NURSING - - - - -	<i>Annie W. Goodrich</i> 512
THE NEED FOR PUBLICITY IN NURSING - - - - -	<i>Gertrude Cowlin</i> 522
RURAL NURSING - - - - -	<i>Alexandra Wacker</i> 527
	<i>Nikica Bovolini</i> 528
RURAL NURSING AS HEALTH CENTRES - - - - -	<i>Mary K. Nelson</i> 530
RURAL NURSING FROM THE VIEWPOINT OF THE PUBLIC HEALTH NURSE - - - - -	<i>Elizabeth Smellie</i> 531
THE PREPARATION OF A CURRICULUM - - - - -	<i>Dr. Stanley Ryerson</i> 535
TRENDS AND DEVELOPMENTS IN VOCATIONAL EDUCATION - - - - -	<i>Dr. W. W. Charters</i> 541
THE COMMUNITY NEED IN RELATION TO THE EDUCATION OF THE NURSE - - - - -	<i>Mlle. Chaptal</i> 544
STATE SUPERVISION IN SCHOOLS OF NURSING - - - - -	<i>Adda Eldredge</i> 545
THE ORGANIZATION OF POST-GRADUATE STUDY IN NURSING - - - - -	<i>Rachel Cox-Davies</i> 550
LEGISLATION IN NURSING - - - - -	<i>E. M. Musson</i> 552
DEVELOPMENTS IN THE PUBLIC HEALTH FIELD - - - - -	<i>Dr. G. B. Roatta</i> 556
THE RED CROSS NURSING PROGRAMME - - - - -	<i>Mrs. Maynard Carter</i> 562
	<i>Lucie Odier</i> 567
	<i>A. S. Gordon</i> 572
	<i>Agnes Chan</i> 572
THE STATUS AND PROBLEMS OF THE PRIVATE DUTY NURSE - - - - -	<i>Jessie Bicknell</i> 572
	<i>E. C. Kaltoft</i> 572
	<i>Janet Geister</i> 573
MODERN DEVELOPMENTS IN PRIVATE NURSING - - - - -	<i>Isabel Macdonald</i> 574
THE ECONOMICS OF NURSING - - - - -	<i>Elizabeth Fox</i> 576

## The International Council of Nurses



HIS issue of "The Canadian Nurse" is given over to an account of the Sixth General Congress of the International Council of Nurses.

Many Canadian nurses were unable to attend that greatest gathering of nurses ever held. It is hoped that through these pages they may learn something of what took place in Montreal. A majority of papers given at general and sectional sessions are published—a few have been slightly abridged.

For two years the nurses of Canada looked forward to this Congress; now it is over, everyone is grateful to the thousands of nurses who attended and so helped in making it a success.

With thirty-four countries represented, there were 357 nurses registered from overseas countries, with 3,034 from the United States of America and 2,822 from Canada, a total registration of 6,213.

Montreal at its best with perfect summer weather made an ideal meeting place for the nurses of many nations. Various civic departments, numerous voluntary organisations, hotels, convents and many individual citizens assisted tremendously in helping the local Arrangements Committee carry through its great responsibilities.

The evening sessions held in the Forum presented a truly wonderful sight as one gazed on row after row of nurses in that vast auditorium, made attractive with the flags of many nations. On the platform, draped with the flags of the member nations of the Council and thickly banked with green plants, were seated the officers and representatives of countries present.

On Monday evening, Miss Gage, President of the I.C.N., who won the admiration of everyone for the excellent manner in which she presided, read a number of telegrams of greeting: among these were those from H.R.H. Princess Arthur of Connaught, State Registered Nurse of England, from Mrs. Bedford Fenwick, Founder of the Council, and from Miss Mary Agnes Snively, Founder of the Canadian Nurses Association. Mrs. Fenwick and Miss Snively were prevented through illness from attending. Addresses of welcome were extended on behalf of the Governor-General and the Government of Canada, the City of Montreal, McGill University and the University of Montreal, the Canadian Medical Association and the Canadian Nurses Association. In replying to these messages of welcome, Miss Gage referred to the splendid way in which the nurses had been received by the people of Montreal.

Tuesday evening's session remains the most memorable. It has been customary for the Founder of the Council to present a "watchword" for the coming years. In Mrs. Fenwick's absence this was given by Miss Margaret Breay, Associate Editor of the British Journal of Nursing. Past Watchwords have been Work, Courage, Life, Aspiration, and the present one is Service (published on page 490).

Then followed the colourful ceremony, when five nations were received into membership: Brazil, Greece, Yugoslavia, Philippines and Sweden. As the representative of each new country was introduced, her national anthem was played by the band of the Royal Highlanders of Canada,

and while the entire assembly stood a Girl Guide mounted the platform with the flag of the new member's country and placed it unfurled in a stand. When the five members had been received, their flags mingled their multi-coloured drapery in one vast scene—"their united insignia a symbol of the common cause just made by their subject-nurses for the benefit of humanity". Miss Lillian Wu, of China, received Brazil; Miss Jessie Bicknell, of New Zealand, received Greece; Mrs. L. L. Bennie, of South Africa, received Yugoslavia; Miss S. Lillian Clayton, of the United States of America, received the Philippines; and Sister Bergliot Larsson, of Norway, most affectionately received her neighbour country, Sweden. Each speaker expressed the gratification of the Council in receiving these new members, while in reply the new members spoke of the inspiration they would receive from being now a part of the Council. Each new member received a large bouquet of flowers, the colours of which corresponded to those of her national flag.

Then a delightful incident occurred, when the chairman, Miss Annie Goodrich, introduced Mrs. Rebecca Strong, veteran among Scottish nurses and who, in spite of her 86 years, came from Glasgow to attend the Congress. As Mrs. Strong rose the "kilties" played "Auld Lang Syne". Then she briefly addressed the Assembly, emphasising the value of education. "Feed your minds, character is essential, but it must have education to be developed." Mrs. Strong thanked the gathering for her reception and its great allowance for age.

Greetings were read from Miss Lavinia Dock and Miss Agnes Snively, pioneer members of the Council, and again many telegrams of greeting were received. Then, in Miss M. A. Nutting's absence, her address on "The Future" was read by Miss Elizabeth Burgess. (See page 492.)

Thursday evening, Miss Mabel F. Hersey presided, when the speakers were Dr. Julius Tandler, Professor of the University of Vienna, Health and Welfare Commissioner of Vienna, Austria; and Dr. J. L. Biggar, National Commissioner, Canadian Red Cross Society. These addresses are published in this number.

Saturday evening saw Miss Gage once more in the Chair, when the Hon. Dr. Manion, member of the House of Commons, spoke on the "Interdependence of Nations," a fitting subject for the closing session of an international gathering. In a rapid resume, Dr. Manion showed nations' interdependence one with another. "No nation can feel that it is not an interdependent portion of the living, breathing, pulsating world of today. The question is, how can we make greater progress for civilisation and bring about that parliament of man, the federation of the world, which is so desirable. There is room in the world for all of us if we endeavour to see each other's difficulties and to understand each other's problems." Emphasising the non-existence of boundaries in the art of healing, he said, "This exemplifies the interdependence of nations throughout the world. The only sovereign they recognise is the sovereign of genius. All nations have contributed and all nations have benefited. All discoverers have ignored national boundaries and given freely of their discoveries to the world. There are no nobler ideals than those dominating the medical world." In closing, Dr. Manion made an appeal for the growth of a true international feeling. His final words were: "Thou shalt love them that fear Him, and thy neighbour as thyself".

Then came one of the most thrilling and delightful scenes of the Congress, when three Girl Guides carrying armfuls of flowers joined





## BOARD OF DIRECTORS

Reading from left: Seated: Sister Larsson, Norway; Miss Breay, England; Miss Noyes, First Vice-President; Miss Gage, President.; Miss Gunn Second Vice-President; Miss Hersey, Canada; Miss Musson, Treasurer; Miss Reimann, Secretary. Standing: Miss Petersen, Denmark; Miss Astrom, Finland; Miss Bicknell, New Zealand; Miss Slater, India; Mrs. Bennie, South Africa; Miss Wu, China; Miss Healy, Irish Free State; Mlle. Chaptal, France; Miss Serton, Holland; Mlle. Hellemans, Belgium; Miss Clayton, United States; Miss Guevara, Cuba.

Sister Bergliot Larsson on the platform. In that clear, silvery-toned voice all had learned to love, Sister Larsson said, "When words no longer convey our meaning, we turn to the beautiful flowers. These dark red roses, the warmest colours, we give to the President of the Canadian Nurses Association". "In the International Council there is a nurse who is giving all her life to keep it together," and presented golden roses and forget-me-nots to Miss Reimann, the Secretary of the Council. To Miss Gage, the retiring President, there was given a beautiful bouquet of pink roses and blue delphiniums. The Council was then presented by Miss Messolara, on behalf of Greece, with one of the lamps of Florence Nightingale, and with one of the old lamps of Greece. Miss Messolara said she hoped her country might shed a light like that of Florence Nightingale, for Greece, through the ages, has shed the light of Aesculapius and of Hygeia, his daughter.

Mlle. Odier, of Switzerland, spoke briefly for the International Red Cross Societies, and Mrs. Sperling, of Germany, expressed thanks for the hospitality she had received while studying in Canada.

Mlle. Hervey, representing the Florence Nightingale School of Nursing at Bordeaux, France, acknowledged a gift of \$28,000 from the American Nurses Association for the erection of the final wing to the School. This school has been erected by the A.N.A. as a memorial to the nurses of the United States who died while on service during the War. The new wing has a large assembly hall, a technical and fiction library, and lecture hall and demonstration room.

Miss Gage, who had so ably filled the office as President, in her closing remarks said she could offer her successor nothing better than the love and co-operation of the 140,000 members of the Council, which had meant so much to her.



Miss Gage then introduced Mlle. Chaptal, the President for 1929-1933, who spoke briefly of her appreciation of the honour done her, stating she was able to accept its responsibility because she had confidence in the zeal for progress and success of the members. The resolutions of thanks were read by Miss Lloyd Still, of St. Thomas's, London.

Then came the moment when the nurses realised the Congress was passing into history, as a representative of each continent bade farewell to Canada. Mrs. Bennie, of South Africa, Miss Guevara, of Cuba, for the Americas, Miss Slater, of India, for Asia, Miss McKenney, of New Zealand, for Australasia, and Miss Astrom, of Finland, for Europe, "with hearts quite literally too full for utterance," brought to a close this great Congress of Nurses, which, in adjourning, Miss Gage said, "And now it devolves on each of us to translate into action the influence of the Congress."

Reports of the affiliated organisations, associate national representatives, and other countries were read at two of the general sessions.

Every country reported effort toward improved educational standards. The stabilising and development of nurses' associations was emphasised; in countries where organisation work is established, the past four years showed enlargement of scope, while in other countries nurse groups are still in the process of unification and require considerable thought and work on the part of the nurses.



The numerous outstanding items of interest in these reports are mentioned under "General Values of the Congress". (page 470).

Other papers given at general sessions are published in this issue.

### *Entertainment*

Many social functions were planned for the entertainment of the Grand Council and visiting nurses.

Delightful garden parties were given by Dr. C. Martin, Dean of the Medical Faculty of McGill University, and Mrs. Martin at their charming home at Senneville, and by Mr. and Mrs. J. W. McConnell at their summer residence at Dorval.

Lovely teas were given by Miss Helen Trenholm at Dixie Golf Club, and by Mrs. Carrington Smith at her home.

Luncheons, teas or dinners were arranged by the English and French Hospitals of Montreal; also a dinner at the Cercle Universitaire.

Seven hundred nurses interested in tuberculosis work were guests of the Sun Life Association. This luncheon was the inaugural opening of the dining room for women in the new Sun Life Building.

The Private Duty Nurses of Montreal were hostesses at an enjoyable tea for eight hundred guests at the Windsor Hotel.

The Overseas Nurses Club of Montreal were hostesses at tea at the Military Hospital, St. Anne's de Bellevue. The guests were nurses attending the Congress who had served with the Nursing Services of the Empire. Seven hundred guests, taken to St. Anne's were given a military motor-cycle escort en route.

At the banquet on Wednesday evening in the two ball-rooms of the Mount Royal Hotel were seated twenty-one hundred, and limitation of space prevented many others being present. National representatives were seated at tables in each room, one presided over by Miss Hersey with Miss Gage at her right, and the other by Miss Holt with Mlle. Chaptal, the incoming president, at her right. The musical programme and messages of greeting from guests at the head tables were broadcast between the two rooms.

Saturday afternoon was also given over to social amenities, when four thousand gathered on McGill Campus for a garden party, at which the band of the Royal Highlanders of Canada again played their delightful music.

Many smaller groups got together for parties of different kinds.

Among visiting nurses who entertained were the National Council of Nurses of Great Britain, with Miss Breay as hostess, and the American Nurses Association, at which Miss Lillian Clayton presided. The nurses of Japan and Korea arranged a really lovely Japanese luncheon, and Mlle. Chaptal, of France, the newly-elected president, was hostess at a luncheon at Cercle Universitaire.

One of the most interesting groups was the meeting arranged by the History of Nursing Society. Most of the two hundred guests who assembled for lunch were members of the Societies of the History of Nursing of Columbia or McGill Universities. Miss Isabel Stewart, who conducted the meeting, described the aims of these Societies, which are to interest nurses in all parts of the world in collecting and preserving all historical facts pertaining to nursing.

Several people spoke concerning the work done in their different countries. It was decided that a committee should be appointed to further this work, and suggested that by 1933, an International History of Nursing Society might be organised.

Miss Stewart announced her intention of giving a prize for the best paper on Nursing History, the conditions to be announced later.

A special invitation was given to visit during the Congress the very interesting exhibits at the Hotel Dieu and at the Osler Memorial Library.

(Any historical material on Canadian nursing that can be collected will be gladly received and carefully preserved at the McGill School for Graduate Nurses.—Editor.)

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### *Sunday Services*

On Sunday, July 7th, previous to the opening of the Congress, special church services for the visiting nurses were held in Christ Church Cathedral and in Notre Dame Church. These special services united with those held on that day as an Empire's thanksgiving for the recovery from long illness of His Majesty, King George Fifth.



## Films

Daily at 5.15 p.m. films were shown in the Auditorium of the Montreal High School. Among health educational views shown were those illustrating diphtheria prevention campaigns, early diagnosis and prevention of tuberculosis, beneficial effects of sunlight for the prevention and care of rickets, advisability of annual physical examinations, the essentials of pre-natal care, the correlation of the Social Service Department with the other Departments of the Hospital, and overweight.

A number of pictures of Canadian scenery were viewed each day, and on Thursday Dr. Tandler, of Vienna, gave descriptive illustrated talks on his work as Health and Welfare Commissioner of Vienna. Dr. Tandler spoke early in the afternoon and again following the evening session at which he had given his address on "The Scientific Method in Social and Health Work."



Representatives of new countries admitted into membership in the I.C.N.

Miss Bovolini, Jugoslavia; Miss Messalora, Greece; Miss Manondgos, Philippines; Miss Fraenkel, Brazil; Miss Lind, Sweden.

## Sections

**PRIVATE DUTY.**—This Section held two very largely attended meetings. At the first one the "Status and Problems of the Private Duty Nurse" was dealt with by a representative from each Continent: Miss Agnes Chan for Asia, Miss Jessie Bicknell for Australasia, Miss A. Gordon for Africa, Miss Else Kaltoft for Europe, and Miss Janet Geister for the Americas. These papers appear in this issue.

At the second session Miss Isabel Macdonald of England presented an excellent paper on "Developments in Private Nursing," and Miss Elizabeth Fox, of the United States, gave an interesting address on "The Financial Aspects of Medical and Nursing Service". These papers, published in this issue, led to an animated discussion, although no conclusions were announced.



THE GARDEN F

**PUBLIC HEALTH.**—This Section was addressed at its first meeting by Dr. G. B. Roatta, of Italy, who spoke on "Developments in Public Health Nursing," while "The Red Cross Nursing Programme" was presented by Mrs. Maynard Carter and Mlle. Odier. These papers are being published.

The potentialities of the citizen as represented by the child and by the adult, were considered in addresses on "The Citizen in Relation to the Public Health Programme," by Dr. Helen Reid, of Montreal, and "The Study of the Normal Child as a Preparation for Public Health Nursing". The physical aspects of this subject were raised by Mlle. Grenier, of France, while Miss Winifred Rand, of the United States, considered the mental aspects. (These three papers will be published in an early issue.)

**NURSING EDUCATION.**—Like the other Section meetings those of the Nursing Education were attended by huge crowds. Dr. Stanley Ryerson's paper on "The Preparation of a Curriculum" created a lively discussion, while "Trends and Developments in Vocational Education," by Dr. Charters, showed that educational programmes in the United States were being influenced by the "job analysis" system. Like several other speakers from the United States, Dr. Charters referred to the aid nursing education and conditions would receive through the study and findings of the Grading Committee.

Mlle. Chaptal dealt with "The Community Need in Relation to the Education of the Nurse".



L UNIVERSITY CAMPUS

Miss E. M. Musson discussed "Legislation as Related to Nursing"; Miss Adda Eldredge's subject was "State Supervision in Schools of Nursing," while "Organisation of Post-Graduate Study in Nursing" was given by Miss Rachel Cox-Davies. All these papers are being published.

### *Round Tables*

Twenty-one round tables were held. These were all largely attended and at each there were present three secretaries, English-speaking, French and German.

Unfortunately, reports of all these round tables are not available for publication at present so that it will be necessary to await their appearance in the official printed report of the proceedings which it was announced would be ready in November, 1929.

Miss S. C. Hearder, Matron, Bethlem Royal Hospital, London, England, led the discussion on "The Need of Education in Mental Nursing in the General Nursing Curriculum". The meeting endorsed that: (1) Psychiatric nursing be included as a compulsory subject in the curriculum of every training school for general nursing; (2) Post-graduate courses in mental hygiene be arranged for graduate nurses; (3) Courses in these subjects be arranged for administrators and teachers in nursing at universities and elsewhere.

Another discussion was, "Nursing in Relation to Mental Hygiene from the Standpoint of the Community," with Miss Katherine Tucker, A.B., General Director, National Organisation for Public Health Nursing, U.S.A., as chairman, and at which Mr. S. P. Davies, Assistant Secretary, State Charities Aid Association, New York, gave a paper, "A Community Programme in Mental Hygiene". Emphasis was made that every public health nurse should develop a psychiatric view-point.

"The Economic Aspects of Nursing and Nursing Education and Nursing Services", led by Miss N. X. Hawkinson, M.A., of Cleveland, attracted an interested audience. Speakers were Dr. May Ayres Burgess, Director, Committee on the Grading of Nursing Schools, U.S.A., Miss Goodrich, D.Sc., Dean, School of Nursing, Yale University, and Miss E. McP. Dickson, of Toronto. Miss Dickson summarised the need for cost studies as follows:

1. To enable the profession to make an authentic statement as to costs;
2. For the satisfaction of the superintendent of nurses, the hospital and the community, to determine whether or not the most economical methods are being employed;
3. For more accurate budgetting;
4. For comparative nursing costs as between one hospital and another;
5. To determine profit and loss in training student nurses;
6. To determine more specifically what constitutes nursing service;
7. To aid indirectly in the standardisation of nursing education;
8. To enable the principal of the school to offer a more business-like contract to student nurses;
9. To determine what method is the most economical for securing for the student a truly general training;
10. To determine how much the nurse in training receives from the hospital in excess of what she gives in service, if any.

The subject of a discussion presided over by Mrs. Bennie, of South Africa, was "Co-operation Between Sister Tutors and Ward Sisters". Those participating were Miss Gullen, Miss Lloyd Still and Miss Cox Davies, of England; Miss Edwards, Miss Densford and Sister Gabriel, of the United States; Mlle. Hellemans, of Belgium; and Miss McKenny, of New Zealand.

This subject, one of the best presented, included mention of the benefits derived from the influence of mutual understanding among co-workers and their meeting together for discussion of existing problems and plans for increased co-operation and organisation.

Mlle. Hellemans, of Belgium, directed the round table on "Ethics of Nursing". In an excellent paper, Miss Lillian Clayton offered a very careful plan of procedure for the development of a code of ethics. In discussion, Miss Mary Roberts said that she would like to see a formulated code of ethics which the nurses of the world might accept as a guide to promote conduct, with such amplification as each country found necessary. Miss Roberts believes "that a satisfying code must be worked out on the basis of practical idealism that shall endeavour to hold such as is still useful of the rich treasure of our past, while it faces eagerly forward to each new day, using new knowledge and new skill as science unfolds new wonders". The teaching of ethics was led by Miss Gullen of St. Thomas's, London. Discussion of actual problems relating to the division of re-



sponsibility between medicine and nursing led to the conclusion that, if nursing is to be a profession, it must be responsible for its own acts and it must prepare students to accept responsibility. The matter of formulating a Code of Ethics for the I.C.N. was referred to the Board of Directors.

Sister Andrea Arntzen, of Norway, was chairman of the round table on Health of Student Nurses, which was discussed under two headings:

1. In "How to Secure Healthy Candidates" emphasis was given to the importance of thorough physical examination of the student upon entrance and at frequent intervals, as well as a record of family history entered. Family history of tuberculosis or mental disease should not be considered at all.

2. "How to Preserve the Health of the Student Nurse" stressed "health education" for the students, who should have out and in-door exercise and hygienic living quarters, and in some cases supervised holidays. The following resolution was adopted: "It is to be recommended that only candidates of good health and strength be accepted for training as nurses. Single rooms affording privacy and quietness and good, ample and varied food ought to be provided. A definite health programme with sufficient outdoor exercise must be arranged for student nurses."



JAPANESE LUNCHEON

A large and interested group met for the discussion of "Recreation for Student Nurses". Activities and suggestions made by speakers from a number of countries showed that similar ideas exist in regard to promoting this important side of the student nurse's life; and also that certain other ideas suitable for some countries could not be adopted in others.

"Government Nursing Services" attracted a representative group, with Miss Elinor D. Gregg, of the United States, presiding. Sub-topics were: (1) "Military Nursing Organisations," led by Miss Rayside, of Canada, who said that the number of Army nurses had increased from 37 to 2,233 during the war, following which, if physically fit, they were placed in other government services. Now there are only 148 nurses attached to the C.A.M.C. (2) "The Government and Nursing Educa-

ton," by Miss Lind of Sweden, reported improved conditions in nursing since the government had taken over all schools. Mlle. d'Haussonville, of France, told of the use of short-term Red Cross nurses in France for Army service. A small number of trained nurses are used, but the supply available is insufficient. Army nurses and Red Cross nurses are not used in the same hospitals. Nurses are under the direction of doctors with no nursing supervision, and salaries are low. Miss Bicknell, of New Zealand, described the public health work carried on by the government. Lack of physical strength prevents educated Maori doctors and nurses from looking after their own people entirely. Miss Perez of Cuba stated that in 1902 all schools were taken over by the government. There are 686 nurses in Cuba at present. Major Julia Stimson described the United States Army Nurse Corps and its Army School of Nursing. Miss Gregg stated that the U.S. Veterans' Bureau Service is probably the largest government nursing service in the world, having 10,000 patients and 2,000 nurses. Miss Bowman described the duties of Navy nurses.

Under the leadership of Mrs. Maynard Carter, at a round table on Red Cross Nursing, two aspects of nursing peculiar to the Red Cross were discussed. These are: (1) Enrolment of the trained nurse; and (2) The training and enrolment of the auxiliary volunteer group.

Representatives of countries participating in discussion were: Miss Clara Noyes, United States; Miss Hagan, Finland; Mlle. Kaebenbeeck, Belgium; Miss Ruby Hamilton, Canada; Mlle. Messolora, Greece; Mlle. d'Haussonville, France; Mlle. Odier, Switzerland; and Miss Feascara, Italy. From the discussion, Miss Mary Gardner made the following summary:

First, that in no issue is there a greater divergence than in the conditions which govern the use of volunteers in the various countries. In some there are a sufficient number of fully-trained and diplomaed nurses to meet not only the normal demands of peace-time, but the extraordinary demands of war and disaster. In other countries the number of fully-trained nurses is sufficient for normal conditions, but insufficient in times of emergency. In still others, there are so few nurses that neither the demands of peace or of emergency can be met by them.

No one of any country could say that the sick should remain uncared for because there were not enough trained nurses to care for them. It would seem, therefore, that in all except a very few countries a subsidiary group of volunteer workers is necessary in times of emergency if not in times of normality.

If this is so certain safeguards must be placed around such a group if the patients are not to be in danger.

First, the relationship between the professional and the volunteer group must be not only close, but sympathetic.

Second, in all professional matters, and in those relating directly to the care of the sick, the volunteer groups should be led and guided by the professional group.

Third, the difference between the two should be made so clear that all may grasp it.

Fourth, since the sick are undoubtedly better cared for by the fully trained nurse, the goal set should be a gradual increase and strengthening of the professional group, with probably a compensating training of the volunteer group.

With these points in mind, and with the keenest appreciation of the inestimable services already rendered by our co-workers, the volunteers, we will do well to draw closer together and to march forward shoulder to shoulder in our common efforts to care for the sick and to prevent disease.

### *Business of the Congress*

The business of the Congress is transacted by the Board of Directors (the officers and president of each member country), and the Grand Council, or voting body (the Board of Directors and four delegates from each member country). The Board of Directors meetings opened on July 2nd, and those of the Grand Council on July 4th.

Observation led one to realise the tremendous amount of time, energy and thought that these nurses give to a Quadrennial Congress.

Other groups equally as busy were the various committees, especially those on Nursing Education and Public Health.

The Secretary's report showed a great increase in the work at Headquarters. Since January, 1926, the Secretary has also acted as Editor of the international journal.

Discussion of this report, together with those from the Committee on Publications, the Special Committee appointed to study "The I.C.N.," and that from the Treasurer, resulted in the Grand Council deciding on an increase in fees from five to eight cents per capita. This decision being provided for by the by-law on fees: "The annual dues from each active member of the Council shall be five American cents per capita or the equivalent in the currency of the country represented as of January 1st of each year," being amended by the addition of the following two clauses:

"The annual dues from each active member may be changed by the Grand Council without previous notice to the affiliated national associations, provided such change is recommended by the Board of Directors and approved by a two-thirds vote of the Grand Council.

"Any change in the annual dues shall not become effective until one year after such change is made."

The above increase is necessary to meet expenses at Headquarters in Geneva, where there must be appointed an Editor or editorial assistance to aid the Secretary as Editor. For the past four years the Secretary has generously been responsible for additional expense; her generosity is deeply appreciated, but the International Council of Nurses should henceforth be placed on an independent financial basis.

The name, "The I.C.N.," has been changed to "The International Nursing Review," and after January 1st, 1930, there will be six issues annually instead of four as at present, and the subscription rate raised to Two Dollars a year (ten Swiss francs).

Other recommendations of "The I.C.N." Committee adopted by the Grand Council were:

1. That the Board of Directors appoint a committee to study the question of forming a Stock Company to float the magazine on a sounder economic basis, or to suggest some other means whereby a sum of money may be secured for the same purpose."

2. That, inasmuch as our Secretary has stated that it is impossible for her to carry on the double duties at International Headquarters, it is recommended that assistance be provided with the publication of the magazine by January 1st, 1930, if funds can be secured for this purpose."

The Council adopted the following resolution as a means to secure funds: "That the affiliated organisations be approached and be asked to make voluntary contributions to meet the deficit on the coming year's work until such time as the new fees are payable, and that the amount of deficit be stated."

On recommendation of the Membership Committee the National Organisations in the following countries were received into membership: Brazil, Greece, Jugo-Slavia, the Philippines and Sweden.

By a unanimous vote of the Grand Council, Honorary Membership was conferred on Miss Nina D. Gage, retiring president.

Place of meeting, 1933.—Invitations for the next Congress were received from France, South Africa and Cuba. By vote, Paris, France, was chosen, and as an invitation to hold part of the Congress in Brussels had been received from Belgium, it was decided to plan that the Congress would be held in Paris and in Brussels.

Officers elected are: President, Mlle. Chaptal; First Vice-President, Miss C. D. Noyes; Second Vice-President, Miss Jean Gunn; Hon. Treasurer, Miss E. M. Musson; Hon. Secretary, Miss Christiane Reimann.



**Mlle. Chaptal, President, International Council of Nurses**  
(See *The Canadian Nurse*, June 1929)

### *Votes of Thanks*

RESOLVED that the sincere appreciation and thanks of the Board of Directors of the International Council of Nurses and the members of the Congress, in Montreal, 1929, be expressed:

To Their Excellencies the Governor-General of Canada and Viscountess Willingdon, for their distinguished patronage and interest in the Congress.

To the Premier, Mr. Mackenzie King, for his warm welcome at the Parliament Buildings, in Ottawa, and to the Government for its generosity in assisting with funds.

To the City Authorities of Montreal, Ottawa and Quebec, as well as the educational institutions of Montreal, for their great contribution towards the success of the meeting.

To the churches of Montreal for the special services arranged for members of the Congress.



- To the nurses of Canada, English- and French-speaking, to whom we owe a debt of appreciative gratitude difficult to express in words.
- To the citizens and hospital authorities of Montreal, who have so wonderfully opened their homes and provided motor service, and have taken so keen an interest in the arrangement of the Congress.
- To the Press, which greeted us upon our arrival and made such excellent reports of the meetings of the Congress.
- To the Canadian Pacific and the Canadian National Railways for so generously making possible the trip of our Grand Council to Ottawa on July 3rd.
- To all the speakers who have contributed so much to the value of the Congress, and to all those whose efforts have made the Exhibits such a great success.
- To the Girl Guides and Boy Scouts, for their graceful service, and to the policemen for their attention and assistance.
- To the Committee of Arrangements, with Miss Hersey as Chairman, and with special reference to the sub-committees: Advisory, Entertainment, Exhibits and Decorations, Finance, Housing, Publications, Publicity, Registration, Transportation.
- To the Programme Committee with its Chairman, Miss Jean Gunn, for its efficient and devoted service.
- To the Officers of the Council, with special reference to the President, Nina D. Gage, and the Standing Committees of the Council, which have done such excellent work during the last quadrennial period.
- To the American Hospitality Committee, which have provided such wonderful opportunities for study for the foreign nurses passing through the United States.

In conclusion, BE IT RESOLVED, that we express our sincere appreciation to the Founder of the Council, Mrs. Bedford Fenwick, with our deep regret that she could not be with us at this inspiring Congress.

### *Secretary's Report* (Summary)

In reporting on the extension of the work, the secretary stated that there were 19 national organisations included in the Council; that since July, 1927, three member organisations had made important changes in their organisation which would affect to some degree their affiliation with the International Council of Nurses. There were eleven associated national representatives: Czecho-Slovakia, Esthonia, Greece, Iceland, Japan, Jugo-Slavia, Korea, Latvia, Sweden, Switzerland and Turkey. Two of these, Sister Emmy Oser, Switzerland, and Miss Mary K. Nelson, Turkey, had resigned.

Altogether, International Headquarters has correspondence with 58 countries, carried on in 12 languages. Thirteen committees have been at work, a large amount of the secretarial work for which is carried on at Headquarters.

The library is growing slowly. There are 55 national nursing magazines in existence. Complete files of three-quarters of these from their beginning are at Headquarters. The library also receives 50 current publications of special interest to nurses. Almost 500 Nursing, Text and Reference Books have been collected, with 100 on general information, and a small number of historical professional interest. There are sixteen languages represented in the library.

**HEADQUARTERS.**—The staff consists of the Secretary of the Council and two assistant secretaries, each member of the staff being of a different nationality. The average number of letters sent out each month is 400. A similar number is received. Many and varied are the requests for information, entailing much work, even research. An increasing number of State Departments request assistance, advice or information re nursing legislation and nursing education. Contact with the League of Nations, International Labour Office, International Red Cross Committee, League of Red Cross Societies, etc., is constantly being made.

Assistance has been given nurses re post-graduate experience abroad. In 1928, 100 requests were received from 8 different countries.

The council was represented at a great number of meetings, national and international, by members of the Board of Directors. Also, it was represented on a few exhibitions of a national and international nature.

With such a small staff only a limited amount of research work can be done.

**PROBLEMS TO BE MET.**—The budget in 1925 was \$4,000, and increased to \$5,500 in January, 1928. It was pointed out that the necessary budget would have to be \$8,000 to cover routine work at Headquarters, as well as Committee work.

Also it will be necessary to provide an editor for the magazine, or editorial assistance, and a field secretary.

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It is impossible to describe the activities of the Arrangements Committee in Montreal. The record of meetings held, especially after January 1st, gives only a bare idea of the plans requiring attention weeks and months previous to the opening of the Congress. The bulk of the work of several of the sub-committees was completed earlier than that of others.

As one studied the Programme one realised the work required before the advertising was secured. The Exhibits made one think of the correspondence carried on and plans made, and no doubt re-made, before booths were arranged and allocated. The Entertainment Committee was among those most anxious for fine weather; they were not disappointed in this, so that their many delightfully arranged affairs were thoroughly enjoyed, while the waiting motor cars with their I.C.N. insignia stickers recalled the hundreds of 'phone calls necessary to assemble veritable "fleets" required to carry the guests to one place or another.

The Transportation Committee's plans revealed well-thought-out arrangements. Finally, as one watched their operation as boat after boat and train following train were met, a welcome given, baggage secured and guests directed to their destination when previously arranged for, or directed to where accommodation could be obtained, one marvelled at this group of nurses' work.

The Publicity Committee's duties commenced early. Articles on Canadian Nursing in its various phases were secured and sent to all member countries. Later the Canadian Press was supplied with material for circulation throughout the Dominion.

The Housing Committee appointed to find accommodation for nurses attending the Congress was assisted tremendously by the Executive Secretary of the General Committee. More than 4,000 had reservation made before July 1st, and every effort was made to comfortably place later applicants. Each rooming house was carefully inspected before being listed as suitable. About 2,000 were accommodated in hotels, and quite



COMMITTEE ON ARRANGEMENTS, MONTREAL

Front row, left to right: Miss Frances Upton, executive secretary; Miss Tasse, representing French-speaking nurses; Miss Mabel F. Hersey, president Canadian Nurses Association and chairman; Miss Margaret Moag, transportation; Miss Esther Beith, registration; Miss Edith Hurley, housing. Back row: Miss Panet Raymond, representing French-speaking nurses; Miss Catherine Ferguson, exhibits; Miss Mabel K. Holt, entertainment; Miss Louise Dickson, secretary; Miss Olga G. Lilly, printing and advertising. Miss Jean Browne, finance, and Miss Ethel Sharpe, publicity, are not in the photograph.

a number made use of hospitality offered by the various religious sisterhoods in their convents.

As one listened to the plans being made for Registration one's amazement grew at the multitude of detail to be considered. The Registration Hall at Headquarters—the Montreal High School—presented indescribable activity during the first days of the Congress. The Committee had the assistance of several members of the Montreal Police Force, and a number of Scouts. Always there were twelve nurses, each with a stenographer and typewriter, on duty (day and night for the first days). The nurses of Montreal registered previous to July 6, in order that there would be less congestion for the visiting nurses. The Committee and its sub-committees' offices were open all day long at Headquarters, which had been made attractive with many plants, cut flowers and the I.C.N. "blue and white" wherever bunting was used. Flags of all nations blended their colours over the main entrance.

The Post Office Department and Transportation and Telegraph Companies kept offices open there.

Each country represented was provided with a class-room for the use of its nurses.

The commercial exhibits attracted large crowds, while the educational exhibits' corridors were filled all day and until closing time each evening. These latter exhibits were especially fine; it was to be regretted that space was so limited. A number are illustrated in this issue.

Transportation from the Forum was facilitated by the hotels having large motor buses ready each evening for their guests.

On Monday and Tuesday evenings, and at the Garden Party, the band of the Royal Highlanders of Canada, in their brilliantly attractive uniforms, supplied delightful music, while for the other two evenings the orchestra of the Canadian National Railways pleasantly entertained the audience while gathering together.

The evenings programmes were broadcast and numerous messages of appreciation were received from those unable to attend.

The Montreal nurses were most grateful for the assistance given them by their fellow-citizens, none of whom helped more than large numbers of boys and girls in their attractive uniforms as Scouts and Guides.

MEMORIAL CHAMBER, VICTORY TOWER  
PARLIAMENT BUILDINGS  
OTTAWA



The Memorial Chamber, which is a small room on the first floor of the Tower, is a sanctuary of rare beauty and deep significance. The walls and the vaulted ceiling are of Chateau Gaillard stone, a present from the people of France; on marble panels around the walls is graven the story of Canada's achievement, surmounted by typical emblems and figures harmoniously grouped in neutral decoration. The three separate windows unite in the general scheme, displaying the ideals and principles underlying the Call to Arms, Remembrance and Peace. In the centre of the Chamber is the Altar, a massive stone ornamented with the Royal Arms, the Arms of Canada and of the Provinces, the gift of Great Britain. On this Altar rests the Book of Remembrance, in which is recorded the names of 60,000 Canadians who gave their lives in the Great War.



## OTTAWA

By courtesy of the Canadian Pacific Railway and the Canadian National Railways the members of the Grand Council, International Council of Nurses, enjoyed a trip to Ottawa, the Capital of the Dominion, on Wednesday, July 3rd.

Upon arrival the guests were met by a large group of Ottawa nurses. Before leaving the station a representation of the City Council on behalf of the Mayor extended a civic welcome to the nurses. Miss Gage, President of the International Council of Nurses, made a brief and fitting reply. Leaving the station, the entire group went to Parliament Hill. In honour of the nurses, the carillon, high up in Victory Tower, pealed forth the National Anthem and Rule Britannia. On entering the Main Building each guest was presented to the Rt. Hon. W. L. McKenzie King, Prime Minister of Canada, who, in an inspiring address, expressed his admiration for the work being done by nurses throughout the world for "the relief of mankind in the great struggle of civilisation". Here again Miss Gage replied on behalf of the nurses.

The Canadian Nurses Memorial in the Hall of Fame was visited, and a number of lovely floral wreaths placed before it. The House of Commons, the Senate, the Library, and the Memorial Chamber were visited.

By courtesy of the Kiwanis Club, the nurses were driven to the Country Club, where they were entertained at luncheon by the Victorian Order of Nurses for Canada, presided over by Rt. Hon. G. P. Graham, President of the Dominion Board of the Victorian Order of Nurses for Canada.

On leaving the Country Club, the nurses were taken for a drive as guests of the doctors of Ottawa. Later, the nurses were entertained at tea in the various embassies. Visits were made to the homes of Sir William and Lady Clark; the Hon. William and Mrs. Philips; the Hon. Jean Knight; and to the Chinese consulate.

To complete what was to be a "perfect day" four hundred nurses attended a dinner at the Chateau Laurier, when the visiting nurses were the guests of District No. 8 of the Registered Nurses Association of Ontario. The president of District No. 8, Miss Gertrude Garvin, presided, and extended a warm welcome to the representatives of foreign countries. Miss Nina Gage replied briefly, stating the pleasure of the nurses in visiting Ottawa. Miss Mabel Hersey, president of the Canadian Nurses Association, also thanked the nurses of the Ottawa district for their hospitality, and for making local arrangements for the visiting nurses.

At both the luncheon and the dinner the Toast to the King was the only one proposed. The floral decorations for the dinner were beautifully carried out, huge quantities of delphiniums and foxglove being used, while each guest at the head table received a small corsage of red roses. The attractively designed menu cards made lovely souvenirs. At the head table were seated Miss Garvin, Miss Gage, Miss Hersey and the president or a representative member of each national organisation affiliated with the International Council of Nurses. Before the close Miss Gage called the name of each member country, in response to which all representatives present rose and were greeted with hearty applause.

A special train waiting to take the guests back to Montreal brought to a close much too soon a most enjoyable and memorable day—one which will live very clearly in the memory of each nurse who was privileged to attend.

## *General Values of Congress*

### REPORT OF THE SPECIAL SUB COMMITTEE OF THE COMMITTEE ON PROGRAMME

In attempting to summarise the general values of the Congress, one is tempted to bear down on the worn-out words—mutual understanding. For the first time, many of us have heard of the activities of our sister nurses, and are both surprised and thrilled to find the same general problems the world over, the same struggles and the same hopes—while others of us, to whom it is an old story, have rejoiced in meeting old acquaintances and hearing of progress since 1925.

The high spot of the Congress for most of us, was probably the colorful dramatic meeting of Tuesday evening, at which the five new members were received as members of the International Council of Nurses.

Mrs. Bedford Fenwick set as our aim for the next four years, the watch-word SERVICE in recognition of the responsibilities the world is entrusting to our profession.

Miss Nutting, although unable to be present, sent us a message in her paper which should prove an inspiration to us in our daily work, when she said, "The one foundation on which the nursing of the future can be safely built is the educated minds and spirits of the nurses themselves."

Sister Bertha Wellin in her paper gave a message which we should all seriously consider, when she said, "The responsibilities of a citizen are inherent in a nurse's life. While nursing ASSOCIATIONS should avoid political entanglements, the INDIVIDUAL nurse should exercise her rights and assume the community responsibilities of a citizen in so far as her time and strength permit."

It is a compliment to our profession that Julius Tandler has seen in it, not only the cold facts of science, but the pulsing blood of life. His

admirable paper has given us many points which we will all consider very carefully. Outstanding among these was the statement that social aid is based on exact knowledge, a science combined with art. Every specialised brand of social service, every step taken by the welfare worker, is grounded on scientific principles. The limit set to all social aid, however, is determined by the personality of the worker.

Very fittingly Dr. Biggar followed with the thought that our civilisation today is moved as never before by a great spirit of humanitarianism. This new concern for the welfare of mankind is seeking a new standard of universal health and adapting measures which will realise the ideal for all classes. No one can be more effective in introducing this new ideal to her fellow-citizens than the nurse, who possesses the knowledge both of caring for the sick and preventing disease.

In and out, like a scarlet thread, in the pattern of our programme, ran Mental Hygiene. There is no doubt at all, that before another Congress there will be great strides in our general knowledge of Mental Hygiene, mental nursing, and our own mental attitudes.

It seems to this committee an extremely significant fact, that out of thirty meetings at this Congress, only one was devoted to the actual practical nursing care of the patient. For one hour and a half, out of approximately seventy-five hours of meetings, the delegates studied new devices and adaptations in the bedside care of the sick. The only redeeming feature in the situation was that the auditorium where the demonstrations were held, was crowded to the doors.

The reports from the affiliated associations, the associate national organisations and other countries, brought out many significant facts:

- 16 countries reported progress in the educational standards of schools of nursing.
- 13 countries reported efforts to secure improved legislation for inspection of schools, nurse practice acts, and registration.
- 8 countries reported standardisation and publication of nursing text-books.
- 9 countries reported plans under way, or completed, for insurance and pension acts.
- 6 countries reported raising special funds for fellowships, scholarships, sick benefits, etc.
- 5 countries reported the establishment of a nursing journal.
- 16 countries reported development in public health nursing.
- 5 countries reported surveys, studies, or analysis of nursing conditions within their own boundaries.
- 4 countries reported new national headquarters.

#### NURSING EDUCATION

A summary of the week's work at this Congress shows quite clearly, that the Programme Committee worked on the assumption that the education of the nurse is fundamental to all else. It is logical, therefore, to begin with Dr. Ryerson's admirably organised paper on the preparation of a curriculum. This paper raised animated discussion, as many of the nurse educators could not agree that nurses need "only a shadow" of the sciences such as Dr. Ryerson indicated, by allotting a very few hours to each. Much of this paper was received with approbation. Dr. Ryerson pleaded for the development of a deeply sympathetic and understanding relationship between nurse and patient, and warned us against the danger of adopting factory methods of efficiency in nursing. He also stated his belief that personality and industry may overshadow knowledge in the making of a successful nurse.

Professor Charters in his paper brought out the fact that through the use of job analysis the older professions have managed their curricula.

Until recently nursing has been almost unaffected by this trend, but the present activities of the committee in the grading of schools of nursing give promise of initiative, vigorous and under spread forward looking developments.

It is with great interest that we note the three countries already making a beginning in this way—United States, Norway and Canada.

#### LEGISLATION

Miss Musson in her paper reported that 95 countries and states have striven for and won legal recognition. Miss Musson concluded her study as follows:

"The standardising of nurse training throughout the world is not, in my opinion, possible at the present time; nor will the establishment of even a minimum standard be possible for many years to come. But nothing but good can come from the sympathetic study of the conditions in all countries and having open and candid discussion at such meetings as these."

Miss Eldredge in her paper on State Supervision in Schools of Nursing, stressed the opinion that State Supervision should mean a general raising of the standards, and ultimately it should mean state aid for schools of nursing.

#### PRIVATE DUTY NURSING

Private duty nursing was most ably presented in six papers from five countries. The papers and the free discussion indicated that the problems of private duty nurses were very similar in all countries, and that they are, in part at least, due to the lack of leadership and organisation, the difficulty experienced by the Programme Committee in finding speakers among those actively engaged in private duty, at the present time, being a case in point. Private duty nurses the world over, need the sympathetic co-operation of all other branches of the profession, solving the problem of hours of duty, income, and of competition from untrained and partially trained persons.

## PUBLIC HEALTH NURSING

Public health nursing drew a large attendance of enthusiastic listeners. Among the truly inspiring addresses was that of Dr. G. B. Roatta, whose description of the scene at which Pasteur proved the value of his vaccine for sheep, will never be forgotten by those who heard it.

To those concerned with the joint duties of public health nurses and social workers, Miss Virginia Robinson's paper was very helpful. She believes that the work of the public health nurse is infinitely strengthened by a knowledge of social work, though a complete course in case work is impracticable. It was also stressed that in her social service effort, the public health nurse should remember that it is the patient who must be roused to reform himself—she cannot do the job for him.

The above summary is very superficial, but we have tried to present the most outstanding features of the programme. The Round Tables are not included, as this committee understands that each Round Table has been given the opportunity of reporting direct to the Congress.

For the planning of future programmes, the committee submits the following suggestions:

- (1) THAT the Congress requires some reorganisation in order that effective work may be carried out during the week, and that it is felt that the large numbers attending the Congress, although indicative of growing interest in the work of the I.C.N., may, unless the Congress is reorganised to meet the situation, hinder the meetings from reaching practical results.
- (2) THAT the general programme be less crowded.
- (3) THAT Round Tables be increased in number to allow for smaller groups and more discussion; that they be organised under certain definite headings, programmes prepared and printed, simplified and summarised in resolutions; that resolutions concerning the subject of the Round Table be printed with the names of those who propose and second such resolutions.
- (4) THAT a General Information Bureau be at the door of Headquarters, staffed by people who not only know the programme but the city and general arrangement of the Congress.
- (5) THAT the Bulletin Board with classified headings be maintained by some one assigned to it.
- (6) THAT the names of officers and chairmen of committees, with their Congress address, be posted at Headquarters for the information of the members attending the Congress.
- (7) THAT the outstanding social function be held at the beginning of the Congress, in order to permit nurses to become acquainted at the beginning of the week's programme.

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Countries represented at Congress:  
 Australia 6, Belgium 9, Bermuda 2, Brazil 7, Bulgaria 2, Burma 1, China 13, Cuba 3, Denmark 8, England 125, Finland 33, France 19, Germany 4, Greece 1, Hayti 2, Holland 11, Hungary 1, India 2, Irish Free State 1, North Ireland 2, Italy 2, Japan 5, Korea 4, New Zealand 7, Norway 11, Philippines 5, Poland 4, Porto Rico 3, Roumania 1, Scotland 39, South Africa 7, Sweden 7, Switzerland 9, Yugoslavia 1, United States of America 3,034, Canada 2,822.



## Summary of Reports

### NURSING EDUCATION

#### I. INTRODUCTION.

The personnel of Committee: Convener, Miss Isabel Stewart, Professor of Nursing, Teachers' College, Columbia University, and a representative from each country connected with the International Council of Nurses.

One of the main functions of the Committee is to keep itself and the International Council informed on the general progress of Nursing Education in all countries, but especially in those countries which are associated with Council.

#### II. FUNDAMENTAL PRINCIPLES IN CONSTRUCTING A CURRICULUM FOR NURSING SCHOOLS.

"Before presenting these results, it may be well to explain that the original idea was to outline a curriculum embodying *minimum* standards for nursing schools. As the discussion progressed, however, it became evident that a minimum which could be accepted for the less advanced countries might be a handicap rather than a help to the countries which had progressed beyond that stage," etc., etc. "It seemed wise, therefore, to direct our efforts toward the outlining of an *optimum* rather than a minimum standard," etc.

"An optimum standard does not represent an impossible or impracticable ideal, but rather those conditions which have been found to be most favourable to the normal, healthy development of nursing students under the conditions that at present exist in most of the countries represented in the I.C.N.," etc.

##### A. The Kind of Curriculum to be Prepared:

1. An attempt to discover and apply some principles.
2. That any curriculum should be used as a guide and not as a law.
3. Opposed to the idea of a rigid and static curriculum, etc. "We believe that there are certain fundamental objectives which all progressive groups of nurses should be able to agree upon."
4. "We believe that we should keep before us the larger aims of nursing practice and nursing education."

##### B. Aims to be Realised:

1. To place nursing service and nursing education on full professional basis.
2. To bring the conception of nursing service to include nursing care of the whole patient, mind as well as body, attention to the whole environment, social as well as physical, prevention of sickness, etc.
3. This broader conception of nursing presupposes a more highly qualified type of nurse than the more routine type of nursing service.

4. It presupposes a higher level of educational work and a different type of educational process, etc.

##### C. What Should Go Into the Educational Programme:

1. Experience and subject matter should be based on present and probable future needs of the student, for the practice of her profession and not primarily on the immediate needs of the hospital for getting work done.
2. Essential that nurses should be prepared to work in different types of communities, etc.
3. Basic course should give good foundation for general practice and in the main fields.
4. Avoid waste in the basic preparation of the nurse.
5. Whatever is essential to the development of an all-around competent nurse should be provided in the training.

##### D. Organisation and Operation of the Educational Programme:

1. Educational programme should be carried out so as to encourage and not discourage the best standards of nursing practice.
2. Programme adjusted to physical and mental capacity of student group and to varying stages in development.
3. The three essentials in curriculum are:
  - (a) The fundamental scientific principles which guide nursing practice.
  - (b) The technical and social skills which constitute the art of nursing.
  - (c) The humanitarian and professional ideals which determine the spirit and attitude of the nurse.

Elements should be balanced in theory and practice, also correlate these.

4. Whole programme arranged in best learning order. Should be definite progress to higher levels and new and more responsible varieties of experience.
5. Equal opportunities for all students for a full, well-rounded preparation in essentials.
6. Definite continuity in fundamental subjects and experiences.
7. Proper distribution of class work, practical work and study.
8. Flexible curriculum makes possible its adaptation to individual differences in ability and educational background.

#### III. DUTIES AND RESPONSIBILITIES OF PROFESSIONAL NURSES.

Necessary to outline in more specific terms the kind of duties and responsibilities which the graduate nurse will be expected to undertake in the *general* practice of her profession: not the specialties, but the fundamental duties and responsibilities of nurse in all common fields of nursing. Duties and

responsibilities common to professional nurses in most countries and which nurses going from one country to another should be qualified to undertake. Outlined under two headings:

1. *Types of cases and conditions in which the nurse should be prepared to give general nursing care:*

- (a) According to age, sex and social status.
- (b) According to stage or degree of illness.
- (c) According to type of disease.

2. *Types of work to be done in the general practice of nursing:*

- (a) Duties concerned with keeping people well.
- (b) General nursing care of sick persons.
- (c) Housekeeping duties.
- (d) Organisation and management of sick room or ward.
- (e) Equipment and supplies.
- (f) Food and diet.
- (g) Medications and drugs.
- (h) Therapeutic treatments.
- (i) Observation of patients, reporting and recording.
- (j) Social and personal adjustments.
- (k) Teaching.
- (l) Professional adjustments.

#### IV. FACILITIES AND CONDITIONS NECESSARY FOR THE ESTABLISHMENT OF A GOOD SCHOOL OF NURSING.

##### A. *Importance of a Good Teaching Field:*

Essential for nurses to obtain practical experience in hospitals with adequate clinical facilities and under conditions favourable to sound educational work. Those responsible in any degree for conduct of nursing schools should have clear understanding of conditions indispensable in any hospital which desires to undertake this important piece of work.

##### B. *Type of Hospital to be Selected for Practical Experience:*

Training schools are found connected with many types of hospitals: State, Municipal, Semi-Private and Private; General and Special; Acute and Chronic; under control of religious, military, philanthropic, educational and commercial organisations, and supported by taxes, voluntary contributions, endowments and patients' fees.

While possible to secure some kind of nursing experience from all these types, it is agreed that the hospital conducted for profit is not suitable for training of nurses. Agreed that general hospital is preferred to special, and hospitals of moderate size (200 to 600 beds), preferred either to very large or very small hospital.

##### C. *Capacity of Hospital:*

"It is strongly advised that the minimum for establishing a hospital school should be placed not lower than 100 patients in the home hospital."

##### D. *Variety of Clinical Services Required for a Basic Training:*

"Committee recommends facilities for medical, surgical, children's, obstetrical nursing

(as distinguished from midwifery) where possible, communicable disease nursing and mental and nervous; care of men and women; active operating service; especial facilities for diet kitchen, teaching diets."

##### E. *Financial Resources and Arrangements:*

Committee believes budget essential, and a budget distinguished from the hospital's budget for nursing service. Strongly advises that in making adjustments (financial), emphasis should be put on the fact that the young nurse is a student and not an employee. Nursing schools should be put on the same self-respecting economic basis as other forms of professional education. State and public authorities to realise responsibility for contributing to and maintaining nursing schools just as they do schools for teachers, etc.

##### F. *Staffing:*

After excluding all nurses engaged in teaching, supervising, operating, out-patient work, etc., committee believes that the ratio of one nurse to four or five patients is reasonable and practically essential during the hours when the ward is most active, a larger number of nurses being assigned to pediatric, psychiatric and private wards. Most favourable conditions where there is a suitable graduate staff of at least one head nurse or sister, one graduate staff nurse to each ward of 30 or 40 patients during the day and at least one graduate to every 100 patients at night. For hospital as a whole ratio of graduate nurses to student nurses approximately 1 to 4.

##### G. *Proportionate Emphasis on Housekeeping:*

Routine domestic work should not be required after the first six months at the latest.

##### H. *Hours, Vacations and Night Duty:*

Committee strongly recommends 8-hour day, 6-day week. Vacations should be at least one month each year, not omitting final year.

##### I. *Housing and Living:*

Residence should be separate from the hospital. Nurses should have the privacy and quiet of individual rooms.

##### J. *Relation of School to Hospital:*

Opinions vary. "Whatever these relationships may be there are two indispensable conditions: adequate financial support and freedom to develop the work of the school."

##### K. *Organisation:*

Whether an integral part of the hospital or separate foundation, the primary purpose of the school should be educational. Should have training school committee. Functions of such a committee or board to study needs of school as an educational institution and to see that it has the necessary staff, etc. Secure and authorise the expenditure of funds.

##### L. *The Administrative and Teaching Staff of the School:*

Must combine the qualifications of executives and educators, must have experience and education along both lines in addition to their

professional qualifications as nurses. Following offices are found:

1. Head of school, whatever her title, should have direct communication with the Board of the Hospital. Should submit regular reports.
2. The head should have usually two or more assistants, assistant matron, assistant superintendent, etc.
3. Supervisors or Oberschwester as distinguished from head nurses or ward sisters. Importance of their teaching cannot be over-estimated.
4. General duty nurse. (Staff or floor nurses.) Select for nursing ability and for potential executive and teaching ability.
5. Sister tutor, instructor, etc. Work is largely teaching in the class-room. Status equal to that of assistants.
6. Lecturers on medical subjects, dietetics, social service, etc. Should be paid.
7. Clerical Staff. Provision also for library service and for health care of students.

#### V. STANDARDS FOR ADMISSION TO NURSING SCHOOLS.

Students must be selected for fitness for nursing.

##### A. Preliminary Education:

Committee agrees that the prospective students should be in regular attendance at a good school at the age of 17 or 18. Education should be of broad, general character, with emphasis on cultural rather than on technical subjects.

##### B. Intelligence:

Intelligence tests should be used when possible.

##### C. Age:

Minimum varies from 17 to 21. Committee recommends 20 as minimum, maximum 35.

##### D. Health:

Secure students who are physically fit, require physical examination once a year thereafter. Mental health of even greater importance.

##### E. Character and Personality:

#### VI. EDUCATIONAL PROGRAMME.

##### A. Length of Nursing Course:

Committee agrees three years should be considered general period to be recommended.

##### B. Division of Time:

Period divided into first, second and third years, certain part of first year set apart for initiation of student. Admitted in groups and not more than two groups in one year.

##### C. Ratio of Theory to Practice in the Course:

Committee agrees on proportion of one hour of systematic formal instruction to ten hours of practical experience.

##### D. General Scheme of Practical Instruction:

E Preliminary Period of First Term (practice in various departments).....	4 months
E General Medical Nursing.....	6-8 months
E General Surgical Nursing (including Gynecology, Orthopedics and Operating Room).....	6-8 months
E Children's Nursing.....	3-4 months
R Obstetrical Nursing.....	2-4 months

R Nursing in Out-Patient Department... 2-3 months  
Elective or Special Services, such as:

R Mental Nursing.....	3-6 months
R Communicable Disease Nursing.....	
R Eye, Ear, Nose and Throat Nursing.....	
R Community or Public Health Nursing.....	

Vacations..... 3 months  
(Night duty is included in the above assignments.)

#### E. General Scheme of Class Instruction:

	Mini-	Maxi-	Recom-
	mum	mum	mum
	hours	hours	hours
1. ELEMENTARY SCIENCES.			
E Anatomy (sometimes given as separate subjects and sometimes combined).....	30	90	60-90
R Bacteriology (sometimes includes Parasitology).....	5	50	20-40
R Chemistry (sometimes includes Physics).....	0	60	20-40
E Personal Hygiene (sometimes includes Sanitation).....	10	50	10-20
R Psychology (usually includes some mental hygiene and pedagogy).....	0	30	15-30
2. NURSING ARTS AND CLINICAL SUBJECTS.			
E Nursing Principles and Practice (usually given in an elementary and a more advanced course including housekeeping or domestic economy, bandaging, rubbing, simple occupations, etc.).....	30	160	90-140
E Dietetics (including normal nutrition, invalid cookery and dietotherapy).....	30	64	40-60
R Materia Medica and Therapeutics (including the preparation and use of disinfectants, the action of common drugs and other therapeutic agents, such as light, electricity, etc.).....	0	45	30-45
R Elements of Pathology (an introduction to the causes and nature of disease, discussing common tests, including simple urine analysis).....	0	40	10-15
R Case Study (an introduction to the study of individual patients from the standpoint of nursing care and nursing records).....	0	15	10-15
E Nursing in General Medical Diseases.....	10	30	20-30
E Nursing in Communicable Diseases or Fever Nursing (including Tuberculosis, Venereal Diseases and Skin Diseases).....	10	50	20-30
E Nursing in General Surgical Diseases.....	30	50	20-30
E Nursing in Surgical Specialties (including Gynecological, Orthopedic and operating room nursing or theatre work).....	20	30	20-30
E Nursing in Children's Diseases or Pediatric Nursing (including child care and infant feeding).....	5	30	20-30
R Obstetrical Nursing (distinguished from midwifery, but including the nursing phases of midwifery).....	5	30	20-30
R Nursing in Mental and Nervous Diseases (or Psychiatric nursing).....	5	30	20-30
R Nursing in Diseases of the Eye, Ear, Nose and Throat (including oral hygiene).....	5	15	10-15
R Emergency Nursing and First Aid.....	0	22	10-15
3. ETHICAL, SOCIAL, HISTORICAL AND PROFESSIONAL ASPECTS OF NURSING ("THE HUMANITIES")			
E History of Nursing.....	10	90	20-30
E Ethics of Nursing..... (Sometimes given together and sometimes separately)			

R Survey of Nursing Field and Professional Problems.....	0	30	20-30
R Modern Social and Health-Movements (sometimes called social economy, social legislation, social medicine or public health—may include epidemiology).....	0	50	20-30

#### F. Main Stages of Preparation:

1st Stage—The Novice or Beginner.

2nd Stage—The Semi-Trained or Junior Nurse.

3rd Stage—The Senior Nurse, who might be called a "pre-professional" or an assistant to a graduate nurse.

#### H. Records:

Of great importance that correct record should be kept of each student and the courses she has completed. Should be evidence that the student has completed all parts of courses specified.

#### VII. STANDARDS OF TEACHING AND TEACHING FACILITIES.

##### A. Teaching Facilities:

1. Class and lecture rooms should be well lighted, well ventilated, quiet and comfortable, with blackboards and other standard teaching equipment.

2. The teaching of both the nursing sciences and the nursing arts require facilities for demonstration and for individual student practice and laboratory work. Without such equipment and the opportunity to make our teaching concrete and practical, it is estimated that at least a half of the value of our class or lecture work is lost. A laboratory (which means simply a work-room) for the teaching of practical nursing is essential. Another laboratory should be provided for the teaching of cookery and dietetics and one for the teaching of the elementary sciences.

3. Illustrative materials in the form of charts, models, pictures, lantern slides, etc., are of great assistance in presenting a subject in a clear and interesting way and in helping students to remember. A resourceful teacher will be able to improvise and collect such materials at little expense.

##### B. Methods of Teaching:

1. The character of the teaching should be equal to that in other professional and technical schools. It should be systematic, organised, scientific instruction, especially adapted to the needs of the nursing group, and such as to stimulate thinking and develop skill in nursing work.

2. This means that teachers should themselves be persons of good fundamental education, well-informed on the subjects they attempt to teach, and, if possible, with some special training in teaching. The nurses in charge of the practical teaching in the wards and other departments of the hospital should be specifically trained for their important teaching duties as well as those who teach in the class room.

3. The largest share of the teaching should be done by nurses, since they understand better the needs of student nurses, are more continuously in touch with them and can apply their teaching better. The sciences can be taught satisfactorily by nurses if they are specially trained for this work. Distinctly medical subjects should, however, be taught by physicians and specialists as far as possible. In clinical subjects such as medical nursing, obstetrical nursing, etc., it has been found that better results are usually secured where a physician (or surgeon) and a nurse divide the work between them, the one discussing the diseases and their treatment and the other the practical nursing measures used in those special conditions. The physicians and nurses selected for such teaching should, if possible, supervise the student's practical work in the same clinical branches.

4. The lecture method has been used to excess in most nursing schools. While it has a place, class discussions, demonstrations, clinics, etc., very often bring much better results. The case study method is one of the best methods for teaching nurses to observe their patients and to apply the principles they have learned to the actual nursing care of patients. It should be introduced as soon as the students have finished their first term's work and should be developed by those in charge of the practical teaching in the wards.

The Committee plans to outline briefly the general content of the practical experience in medical nursing, surgical nursing, etc., and also the subjects included in the programme of class instruction. It hopes also to round out some of the points which have been discussed too briefly in this report.

Another problem which has been referred to the Committee is the definition of the term "trained nurse" and "trained graduate nurse" as used in the constitution of the I.C.N. A report on this subject will be submitted later.

### Public Health Committee

QUESTIONNAIRES SENT OUT IN THE LATTER HALF OF 1926. RETURNED IN 1926 AND EARLY IN 1927.

Questionnaires sent out.....	19 Members	} 30
	11 Associates	
Returned.....	17 Members	} 24
	7 Associates	
Not returned.....	2 Members	} 6
	4 Associates	

Not returned: Members... China  
India

Associates... Czecho-Slovakia  
Japan  
Jugo-Slavia  
Switzerland

Incomplete, as stated on return: Canada  
France  
Turkey



THE INFORMATION GIVEN BELOW WAS  
OBTAINED FROM THE FOLLOWING  
COUNTRIES:

Belgium	Italy
Bulgaria	Irish Free State
Canada	Iceland
Cuba	Latvia
Denmark	New Zealand
Estonia	Korea
Finland	Norway
France	Poland
Germany	South Africa
Great Britain	Sweden
Greece	Turkey
Holland	United States of

America

Public Health Nursing, as it stands to-day, still in the process of evolution, grew, in a number of countries, out of a District Nursing Service. This was the case in Great Britain, where it was started in Liverpool in 1859 by Mr. Rathbone, and in Sweden, Denmark and Latvia, where it was started by the Deaconesses between 1860 and 1870.

Canada dates its beginning of public health nursing from the establishment of the Victorian Order of Nurses in 1897; while in a number of other countries the start was made with Child Welfare work; examples of this are Finland, 1904; South Africa, 1908; and Greece, 1919. Other countries began with tuberculosis nursing, as for example, Cuba in 1909 and Bulgaria in 1914.

TOTAL NUMBER OF PUBLIC HEALTH NURSES  
IN THE VARIOUS COUNTRIES

The number varies—from a few nurses in Bulgaria, Iceland and Korea, to 1,200 in Holland, 10,000 in Great Britain, and 12,000 in the U.S.A.

PUBLIC HEALTH NURSES ARE ENGAGED IN  
Visiting Nursing  
Child Welfare Work  
School Nursing  
Tuberculosis Nursing  
Industrial Nursing  
Mental Hygiene  
Hospital Social Service.

By far the greater number are doing visiting nursing and Child Welfare Work. In some countries a fairly large number undertake tuberculosis nursing, while Mental Hygiene and Hospital Social Service have not yet begun. This is true in countries where nursing on modern lines has only been begun within this present century.

EDUCATION OF THE PUBLIC HEALTH NURSE

The preliminary general education of the public health nurse seems to be somewhat unsatisfactory. The U.S.A. is the only country where four years High School is generally aimed at. Belgium, Bulgaria and Cuba require some secondary education, whilst all the other countries seem to build mainly on a primary education, although it is almost universally stated that students with secondary education are given preference.

In regard to the professional education, Canada, Cuba and the U.S.A. require full training; the Irish Free State states that 99% of its public health nurses are full-

trained. Examples of the percentage of full-trained nurses in other countries are: Belgium and Great Britain, 75%; New Zealand, 65%; Norway, 60%; Italy, 35%; Finland, 33%.

POST-GRADUATE COURSES IN PUBLIC  
HEALTH NURSING

A number of countries have courses in Public Health Nursing. In the United States and Canada a number of such courses are connected with the different universities. Cuba, Finland, Great Britain, Holland, New Zealand and South Africa, have courses of varying duration (2 to 12 months) connected with various institutions or organisations. Some of these courses teach only the specialties, such as Child Welfare Work or Tuberculosis. Others offer courses in General Public Health Nursing.

The percentage of nurses who have taken such courses vary; the percentage in the U.S.A. being comparatively small, where the number of nurses is large; in Canada, 50%; in Finland, 88%.

In Bulgaria and France the training in public health nursing is included as a part of the basic general training.

PUBLIC HEALTH ORGANISATIONS

In practically all of the countries public health nursing is undertaken by official agencies, state, county, city, or by voluntary agencies, private, endowed, religious, Red Cross, and others.

TYPE OF WORK DONE

The work in most of the countries is both generalised and specialised.

Specialisation is most common in urban work, and generalisation in rural work. In the U.S.A., however, a generalisation is predominating. Specialisation is most common in New Zealand and Poland. In Bulgaria, Cuba, Estonia and Iceland practically only specialised work is found.

HOURS OF WORK AND VACATION

The weekly hours of work vary in different countries between 30, 33, and 35, which are respectively found in Italy, Greece, Cuba and South Africa, to 60 and 65, which are found in Norway and Iceland, variation being found within the countries themselves.

Vacations range from ten days (Great Britain and Italy) to six weeks (Belgium, Norway, South Africa and Irish Free State).

PROMOTION

In the countries with a great number of public health nurses there are satisfactory possibilities for promotion (U.S.A., Great Britain, Canada). In the countries where the great body of the nurses work alone, Belgium, for instance, promotion is difficult.

In other countries, of which Denmark is an example, there are very few administrative positions available.

In almost every country responding, public health nursing is growing in importance and scope.

Convener of Committee, Miss Mary S. Gardner, Director, Providence District Nursing Association, Providence, R.I., United States.



Mrs. REBECCA STRONG

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*Mrs. Strong was for forty years Matron of the Royal Infirmary, Glasgow, Scotland. Following the Congress Mrs. Strong spent several weeks in the Canadian Rockies. While at Banff she celebrated her eighty-sixth birthday.*

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### *Exhibits*

Among the many interesting exhibits in addition to those illustrated on the following pages were: The Canadian Tuberculosis Association; the Canadian Council on Child Welfare; the Victorian Order of Nurses for Canada; the Metropolitan Life Insurance Company; the Hotel Dieu, Montreal; the Canadian Red Cross Society; the Province of Manitoba, and a second exhibit from the United States.

All exhibits were most interesting, many showed the different nursing services in the countries represented. The International Council of Nurses exhibit illustrated the Council's development throughout the world. The National Council of Nurses, of Great Britain, had been able to arrange for their exhibit to include a number of personal belongings of Florence Nightingale, which she had used in the Crimea; among these were a Bible, a black silk costume and bonnet with a black lace shawl, a grey wool shawl and an agate cup.

Large numbers visited each day the attractive dolls in uniform, the maps, graphs, photographs, charts, records, ward equipment and nursing appliances, many of which had been brought long distances to contribute to the interest and success of the Congress.

The progress made in the care of the patient and the evolution of the nurse of fifty years ago to the present day, was most effectively illustrated as part of the exhibit from the National League of Nursing Education, United States.



INTERNATIONAL COUNCIL OF NURSES



GREAT BRITAIN



UNITED STATES



CHINA

DENMARK

JAPAN



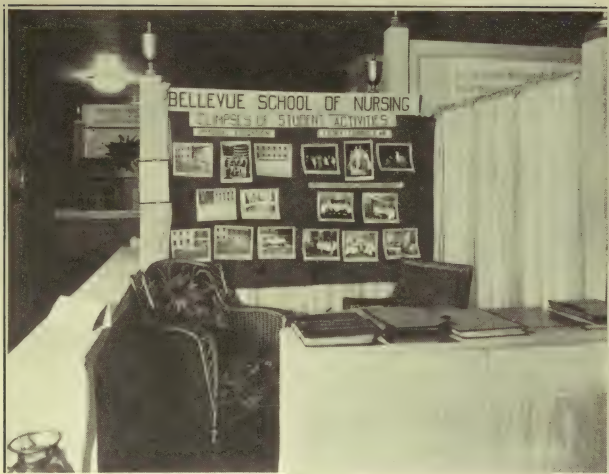


NEW ZEALAND

HOLLAND



SOUTH AFRICA



BELLEVUE SCHOOL OF NURSING



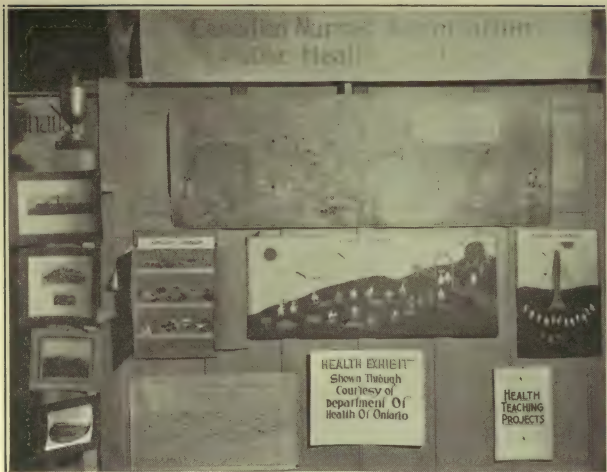
SHRINERS' HOSPITALS FOR CRIPPLED CHILDREN



NURSING EDUCATION SECTION, CANADIAN NURSES ASSOCIATION



NURSING EDUCATION SECTION, CANADIAN NURSES ASSOCIATION



PUBLIC HEALTH SECTION, CANADIAN NURSES ASSOCIATION



PRIVATE DUTY SECTION, CANADIAN NURSES ASSOCIATION





CANADA



DEPARTMENT OF PUBLIC HEALTH, TORONTO

## PRESIDENT'S ADDRESS

By NINA D. GAGE

This is the thirtieth Anniversary of the founding of the International Council of Nurses. In 1899 in London, Mrs. Fenwick sounded the call, and individual nurses from six different countries joined with her and the Matrons' Council and founded our International Council.

It is fitting that at this, our thirtieth Anniversary, we remember first some of those who helped build us, but have now gone ahead and left to us the responsibility not to let the lamp grow dim, but keep it ever brilliant to light our profession on its path of works for and with others toward the help of our fellow men.

We miss from our ranks many who have given us valiant help in the past years and whose absence means much loss, personal and professional.

Baroness Mannerheim, who guided us so graciously and skillfully through the last Congress in her beautiful and cordial country of Finland, whose splendidly organised nursing we should have found it difficult to see without the "Open Sesame" of the International Council, has gone before.

Schwester Agnes Karll, another former president, and also a perpetual Honorary President of our Council, whose work helped so very greatly not only the International Council of Nurses but also the German nurses, in her early years, is no longer with us.

Flora Madeline Shaw, whose help at the last Interim Conference at Geneva meant so much to us, and whom we had hoped would welcome us here in Montreal, greets us in spirit, and has set us an example of constant, cheerful, friendly co-operation with others which meant much in her own work and will mean much translated into ours.

Anna C. Maxwell, one of our foundation members, always ready with advice when wanted, still strengthens us as we study her life's work.

Grace Neil of New Zealand, and Mina Mollett of Great Britain, founder members, leave us a great deal to be learned from their example of hard work and clear thinking.

In 1901, in Buffalo, was held the first meeting of our Council, still with no organised nursing associations affiliated, since there were not enough of such associations in existence. We are glad to have some of our foundation members with us at our thirtieth Anniversary, to watch the work of their hands and see the changes and progress which have come in thirty years. The first president, Mrs. Fenwick, in her address at Buffalo, put the emphasis on work, and the necessity for organisation. Among other things discussed at that Conference were many for which we are still striving.

1. WHAT SHALL CONSTITUTE THE TRAINED NURSE?—The "job analysis" is still being made in places, and would seem very necessary before the best method of preparing anyone for a job is worked out, before better curricula can be decided. Much of this will of course have to be done by each country individually. Basic requirements for bedside nursing are the same the world over, but details vary as equipment varies. Other avenues of "helping the patient to live" open to the nurse as her community finds her aid valuable. In America there are some sixty-five of these avenues opened. In China the nurse has not yet been asked to do so many things. But that is small wonder since even the word "nurse" in the Chinese language is only fifteen years old. Demands on the profession are growing, as you will see from the reports they will present later in the Congress. Other nations are finding the same thing true. We shall hear much of interest in the next few days.

2. STATE REGISTRATION has been achieved in many places, and registration by the Nurses' Associations has been made a substitute in other countries where government action does not seem advisable or possible just yet. Protection of the public from danger, and of the good name of our own profession are being attained, and will, we trust, become universal before many more Congresses are held.

3. LOCAL AND NATIONAL ORGANISATIONS of nurses were being urged thirty years ago, and in more and more countries are coming into being nowadays. As soon as even a few nurses are present, they begin today to form associations and prove that "in union there is strength." In China before there were more than two or three Chinese nurses, the association was formed, and the ground work laid, ready and waiting for them. Now there is the happiness of seeing the Chinese come into their own, and we have the joy of a Chinese President, Secretary, Treasurer, and several delegates to the Congress, instead of a single one as at the last Congress at Helsingfors. We have Chinese taking active parts in association work, and thus learning how to take their part in the world's work.

4. PROFESSIONAL MAGAZINES have been started in most countries where there is the slightest organisation, and grow as the profession becomes articulate. They are an excellent means of promoting free discussion, and expression by the members of the profession.

5. ARMY NURSING was well demonstrated in the last war and has proved its value for serious work over many of the attempts of the Voluntary Aid Detachment. The question was very acute thirty years ago, following the Spanish-American and the Boer Wars. In at least one country at the present time an army school of nursing has grown up with higher standards than the average of schools, and graduating into our ranks a most desirable element.

Other subjects of discussion at that first Conference show less progress than these just mentioned. Codes of ethics have been discussed and discussed, but very little has been organised into formal statement. Some pronouncement of principles would be very useful and helpful not only to ourselves, but to the public who need to know the principles upon which our actions are based, so that they may distinguish before too late between the real and pseudo members of our profession.

Uniform requirements for schools of nursing and uniform curricula are among the things being studied by our International Education Committee. They will probably prove difficult to promulgate, in our present stage of development. So much must depend on local needs, thought, opportunity, equipment, not only physical but mental, that only minimum necessities can ever be uniform. The study of the Education Committee as to how much such a minimum can cover will be most illuminating.

#### PROGRESS IN THE LAST QUADRENNIUM

Since our last Congress at Helsingfors we have made history along certain lines. First might be put the establishment of INTERNATIONAL HEADQUARTERS, already beginning to serve as a clearing house for information on nursing matters throughout the world. Our wide awake and capable secretary has made us known in Geneva and many other places, made our professional capabilities respected, and informed others of our activities.

OUR LIBRARY should grow much larger, but beginnings have been made. With the efforts of each one of us, references will be added, and the library become a centre of nursing literature and for study and research in nursing questions such as should be valuable for the future improvement of our profession.

OUR MAGAZINE many of you know, and many more can become acquainted with it from the sample copies shown at this Congress. How our Secretary

finds the time to edit it, among her manifold other duties, is a puzzle, the answer to which is known only to herself. None of us can afford to be without at least one copy, if we are to keep abreast of the latest issues and most important problems in our profession as they arise. And we should also subscribe as an assistance to our International Council. The proceeds from increased subscriptions would go toward the salary of someone to help our Secretary, who so greatly needs aid in the office. The editorship of the magazine alone, such a magazine as she has made it, would be a full-time task for most of us, with all the translation necessary. But this is only one of the things which she accomplishes.

THE NEW CONSTITUTION, adopted at Helsingfors, has proved a splendid basis on which to work, and only minor changes proved desirable at this time. We are certainly grateful to the committee which worked on it so untiringly to present at Helsingfors.

Two years ago, in Geneva, was held the INTERIM CONFERENCE, which aroused interest, since we had delegates from thirty-four countries, one more than at Helsingfors. It gave us much inspiration, and introduced many of us concretely to the League of Nations, since they received us, and talked over with us some mutual problems. We had a chance to meet many of the Swiss nurses who helped receive and entertain us, and some of whom are with us today. Our Secretary did most of the organisation for the Interim Conference. We owe her very much, with Conferences, magazine, headquarters, information, encouragement, assistance in all sorts of nursing problems throughout the world. Without her we should be nowhere near our present stage of development. We must find some way to give her help. She could make many interesting studies, and help the profession greatly by her research, if she could be freed from some of the routine duties. This is one of our greatest organisation problems, which must be solved soon before Miss Reimann's health gives under the strain.

And now, thanks to the generosity of the Canadian nurses, we are meeting here in this beautiful city of Montreal, the first place where nursing became known on this side of the world. China still regrets exceedingly that circumstances beyond the control of the nurses made it impossible to receive us there this year. But the Revolution is bringing about a better country, where nurses will find it much more possible to make themselves useful, and we hope that before too many more Congresses the Nurses' Association of China will be able to repeat its invitation. Meanwhile, the Canadians have been working valiantly and have prepared in only two years the welcome which we are finding all around us. We cannot be too grateful to our hostesses, and can show our gratitude not only by our appreciation now, but by our translation of inspiration into action on our return to our duties.

The problems before our profession are many and great. I shall not dwell upon them, because Miss Nutting will present them so much better to-morrow night. But they need clear thinking and much study. How can we enroll better students in our schools? How can we better prepare them for their work? What changes are necessary in our schools and our organisations to enable us better to serve our communities? Many so-called schools are not real schools, and must be reorganised and get money for endowment, as Miss Nightingale's school did.

The hours of work of most nurses in many countries are too long to permit the best care of patients, because of the fatigue entailed upon the nurses. We should re-read the discussions of the 1912 Congress of our International Council at Cologne, and bring these things before the public.

Through all our problems runs the scarlet thread of our ultimate object, better care of the patients, whether in home or hospital, ill or being prevented from becoming ill. To us this is self-evident. We are never quite happy when divorced from the patient. We



prefer night duty because it keeps us closer to the patient without irritating, though necessary, red tape and day-time formalities. Fifty-four per cent of us, in America at least, and probably more in other countries, prefer private duty to other forms of work, because there we have the patient without so many outside disturbances. It is a thrilling thing to see him improve under our administration, or to see him follow health teaching, and escape becoming ill. We prove that we like these contacts by the way we keep to them. We are unhappy when someone asks those of us in an executive or teaching position why we are not nursing. We do not like it, when, in our attempts to improve the education of our pupils, and therefore their preparation for their job, we are asked the frequent question, "Who is to nurse the patient if you keep on pushing up requirements?" We become impatient at other people's lack of understanding of our purpose. Yet is not some of the misunderstanding our own fault? Have we shown outsiders clearly enough why we want to lift ourselves up from the apprentice stage, why we feel the need of better preparation? Few of us are like our pioneers, Florence Nightingale and some of those of whom we have spoken today. We cannot educate ourselves, make our own correlation between practice and the necessary scientific basis for our better care of the patient, as they did. Therefore we, and they, too, recognise the need of better schools, and opportunity for further study after graduation, study in schools and hospitals. But just because it is so self-evident to us, and because we do so little talking, we give a false impression to the public that we are trying to get away from practical work. This false impression I have seen in America and China, and some signs of it in other countries. I would warn those of you where it has

not yet happened to learn from those of us where it has, that more enlightening of the public is necessary, more emphasis on the reasons why we want to improve preparation, and more showing of results. One school among us with the best of modern preparation is now sending out its first graduates, who are turning to private duty and bedside nursing because they appreciate the importance of that work and the opportunity given by it for saving their fellow men. Make this clear to the community, prove that with better preparation you will give better service, and the public will support you.

In this way to win the co-operation and assistance, moral and financial of the people round about us toward our better preparation, is one of our most necessary and pressing tasks today. On our success depends the possibility of keeping the interest and support of our public, and so our work for our patients and neighbours, and thus for our country. We must make them feel our deep interest in their welfare, physical, mental, spiritual. And so our co-operative work becomes again individual, and we act and react on each other. May we prove the value of better preparation and organisation, not only professional organisation for the discussion of our problems, but community organisation for putting us in touch with our patients, as Finland in 1925 showed us their community organisation for child welfare. Organisations like these will so improve our care of our patient that the public will see and know our aims, and how we realise them, and they will feel and know that our patients and neighbours are the centre of our thought and effort, sympathy and feeling. In this way we shall be able to translate our principles into action, and move forward with a united front according to our Constitution through our world-wide organisation to "ever higher standards of . . . public usefulness of our members."

*The Watchword... Service*By **ETHEL G. FENWICK**

From the foundation of the International Council of Nurses it has been a laudable custom to give a Watchword which shall be the working motto of the Council from one meeting to



Miss Margaret Breay, S.R.N., F.B.C.N., Associate Editor, *The British Journal of Nursing*, who in the absence of Mrs. Fenwick, Founder of the International Council of Nurses, read *The Watchword* and acted for Mrs. Fenwick on the Grand Council.

another; Work, Courage, Life, Aspiration—each in turn has served to unite the Members of the Council in a common endeavour.

**WORK**—The task of building up National Councils of Nurses in every land, the result of which you see before you in this great Congress.

**COURAGE**—"All progress is strife to the end," and the nurses of many nations assembled in this hall know that to effect the organisation of a profession, in the face of opposition, pioneers who dare to stand alone need to take their courage in both hands. Much has been done since this Watchword was given in 1904 to raise the standard of nursing, to organise nurses, and, consequently, to improve the care of the sick. It has required Courage.

**LIFE**—To proclaim that health and happiness are synonymous, to teach fearlessly that the well-spring of life must be pure—to contaminate it a crime; and that the life-giving elements are the common rights of the community. Here, too, the work of the Nursing Profession is resulting in many directions in fuller life.

At our Congress in Cologne in 1912, I gave as our Watchword **ASPIRATION**, and invited our affiliated associations to translate it into accomplishment during the next triennial period, especially in one particular: "Do not let us allow the inspiration of our Conference to evaporate in sentiment. We need to capture, concentrate and utilise it as a compelling force in the upraising and resultant happiness of all things sentient.

The Watchword which I have chosen for our next quadrennial period—**SERVICE**—links together all the others in a common purpose. We are happy that our profession is a vocation of unlimited opportunity of service to the world at large, and wide sympathies, knowledge, kindness, tenderness, all are needed to meet the demands of our daily work.

Since the first Watchword was given the large majority of nurses have not only become professional women registered by the State, but they are enfranchised citizens whose duty it is to aid in the acquisition of knowledge with the aim of promoting a high standard of National Health, for upon physical advancement and health the whole social evolution of mankind is dependent.

In the development of this social evolution it is the high privilege of the Nursing Profession to play an honourable and indispensable part, and for this to be effective the nurse must first study and keep in her mind the normal standard of health. It should then be her constant endeavour, by precept

and practice, to bring all with whom she comes in contact to approximate to this standard, and to give skilled care to those who fall below it, so that they may be restored to the normal standard at the earliest possible moment.

The most precious possession of mankind is health; it should be the heritage of each one born into this world; its impairment is inevitably a handicap in the race of life, and it should be a reproach to any nation if the health of its people is below that attainable.

It is the mark of a profession, and more especially of a profession such as Nursing, which is concerned with the service of humanity, that its members are ever on the watch for a wider field of Service.

Half a century ago a nurse's choice of a career was practically restricted to general hospital nursing, private and district nursing. Now the door stands wide open. Opportunities are unlimited.

In the Public Health Service, including maternal care and infant welfare, the great services which care for our sailors, soldiers and airmen, the care of mental and infectious diseases, and prison, industrial and insurance nursing, the nurse's services are eagerly sought. Educational posts include the Sister Tutor, and in journalistic and secretarial positions in connection with Nurses' Organisations the Registered Nurse is indispensable.

And we may glory in the knowledge that this great increase of opportunity is ours because of the faithful service, in such restricted spheres as were open to them, of those who have gone

before, that its value was so recognised that the desire for it became more and more insistent. The reward of our service, and the measure of its success, has been the ever-increasing call for a rising quality of service.

Each generation has its own peculiar problems. The foundations of our profession have been well and truly laid, minimum standards of nursing education have been defined, the nurses of today have come into their heritage of legal status and an assured position in the body politic without effort on their part. Their problem is how to render "true and laudable service"—to meet the constantly increasing demands upon their organising ability, skill and kindness—and the one without the other is largely discounted—so that they shall not fail the public who rely upon them, so that they shall serve one another in their organisations loyally, willingly and with energy.

How is all this to be achieved? Yours is the problem: I leave it with you, knowing that you will not fail your generation, but, like your predecessors, will strive to develop your chosen profession, and to raise it to a still higher plane.

Lastly, permit me to remind you that on the lips of Solomon's "virtuous woman," whom we do well to take as a model, was the law of kindness. The world is athirst for kindness. Offer it in abundance, just acts of grace. Little unremembered acts like jewels, tiny jewels, in a larger setting which we can all win and wear—the Crown of Service—a Crown for ever ennobled, because of its association with a Crown of Thorns.

## The Future

By M. ADELAIDE NUTTING, M.A.,

*Emeritus Professor of Nursing Education, Teachers' College, New York.*

Before the immensities of this title one may, I trust, be pardoned for faltering, and for taking the liberty of modifying it to something of a less venturesome nature; to an attempt instead to consider briefly the educational foundations we are making for the future of nursing.

"The Communion of Saints," says our most modern of philosophers, Alfred Whitehead, "is a great and inspiring assemblage, but it has only one possible meeting place, and that is in the present. The present contains all that there is. It is holy ground, for it is the past and it is the future."

The present does indeed seem "holy ground" as we gather in this city of memories; a city whose archives preserve, and whose beautiful statues enshrine the story of the heroic deeds nearly three centuries ago of Jeanne Mance, the founder and first nurse of the Hotel Dieu; a city which has watched the endless throng of devoted women, long of one faith, now of many faiths, who have followed where she led the way. We can still catch the glow of the flame which inspired them in the generous lives and labours of the nurses of today.

A study of the past can tell us a good deal about how we have reached our present stage of growth and development, and it is easy to trace in various phases of these, throughout the years, the ideas and efforts of those among our predecessors who were constantly searching for better ways, and constantly labouring to bring them into being.

In trying to see what kind of a future is in the making for nursing and for nurses we shall need not only to know existing conditions but to know also something of conditions in the past, in order to understand the

nature of the influences which have shaped the present. Let me pause here to say that while the subject in its elements is of the gravest importance in the development of nursing anywhere, I must necessarily limit my discussion to the conditions in the United States with which I am most familiar.

A distinguished educator thus describes three successive stages of growth through which the professions usually pass. The first stage is *expansion*—more schools, more students—this makes inevitable the second stage, that of *standardisation*—set up standards and enforce them as far as you can. Then follows the period of criticism—the educational effort must justify itself by its results. Nursing is still expanding, still trying to create its standards, and is very much engaged in critical study and analysis of its work and educational system. But before there was any professional education, there was the still earlier stage of *apprenticeship*. This still exists widely in nursing though not elsewhere, and nursing is therefore peculiar in that it seems to be struggling along in all four stages of growth simultaneously.

The writer describes nursing aptly as an *emerging* profession—unquestionably professional on its highest level, but not completely so on its lowest.

Let us glance at the picture which nursing presents today. It is an impressive one in numbers—there are hundreds of thousands of nurses in the working world, and they form, next to teachers, it is said, the largest existing body of professional women. Impressive also is their field of work; the vast ranges of human effort concerned with the relief of, suffering, the care of the sick, and with the protection of health among the people.



This vital field is so varied, so continuously expanding, that at times it seems almost to defy limitation.

The complex mechanism of the modern hospital cannot move without an organised body of nurses. To carry on its unceasing activities they must be here, there, everywhere—at the bedside, in the operating room, in clinic, in laboratory. There are those who nurse, those who supervise nurses, and others who are responsible for the direction of all nursing in every department of the hospital, day and night—the hospital, indeed, seems to belong to this body of nurses—to be its natural home. In many hospitals this nursing service is also a school for the training of nurses—the duties just outlined are performed by student nurses, the supervisors are their teachers and the superintendent of nurses combines her executive task in the hospital with the administration of the school and assumes the educational duties which it involves.

By far, however, the larger number of sick people are not cared for in hospitals—they must be nursed in their own homes; and since no two households or individuals are alike in their needs or demands, since the crisis of sickness sets up in each troubled domain its own special requirements, it is inevitable that this sphere of nursing should be peculiarly exacting. It is an important and difficult field of ill-defined duties and responsibilities and of delicate personal adjustments. It calls for the judgment that comes from knowledge, and for sympathy born of understanding. More than half of all nurses, it is said, are engaged in this work of private nursing families.

The early idea of nursing was the care of the sick, but Florence Nightingale had a different conception of the meaning of the word, and pointed out that there were nurses of the sick and nurses of health, and today it is recognised that the successful growth of the public health movement

has become dependent, in essential ways, upon the activities of such workers, now called public health nurses. Their energies are centered mainly in efforts to prevent sickness, to detect disease in its incipient stages, and bring it under medical care at a time when it can be controlled, and their tasks call them to such points in the social structure as offer the largest promise of fruitful results. They are thus occupied in thousands, and their lines of work are interwoven between homes, public schools, clinics, factories and shops, and in increasing numbers in the health departments of city and state.

This meagre presentation of the field of nursing does little more than barely outline the three main branches of work in which nurses are now universally engaged, and as we consider the seriousness of their nature, the unusual and varied conditions under which they are carried on, the responsibilities they involve, and the amount of knowledge and understanding required, we are impressed anew with the extraordinary difficult problem which the educational preparation of such a body of workers presents. It has always been and is today, the great problem in nursing.

Up to a recent period the only preparation available in most countries for any branch of nursing, was that provided in hospital training schools, and this is still all that most nurses can obtain. There are, however, certain nursing schools conducted under independent auspices, of which noteworthy examples are found in France and Italy, but these are few in number.

These hospital schools exist in thousands. They represent an established system in which the essential characteristics are alike throughout in each institution, a system which places schools of nursing in the position of hospital departments, responsible for the conduct of all nursing activities. The educational ideals of

these schools are shaped to conform with such hospital activities, and their growth and development are, in the main, restricted to the opportunities lying within the spheres of the hospitals with which they are connected, or with other hospitals of special types.

That the close connection of nursing schools with hospitals is indispensable in the training of nurses may be taken for granted; we can see no rational scheme for the education of nurses in which hospital training would be any less essential or important than it is today. We would, in fact, make it more important; but we can also see, that long before this there should have been proper safeguards erected to protect nursing schools from the complete subjection to hospitals into which they have fallen: from becoming the proprietary schools which they now are almost universally.

The Chancellor of a prominent American University, in a recent discussion of the education of nurses, pointed out that nursing exhibits the only profession left in which the student is looked upon as a source of profit. Inherent in the system that permits this lie almost measureless possibilities of exploiting student-nurses in the service of the hospital; the only check upon this must come from the conscience of the individuals directing their activities; the system itself provides none.

But people transcend the systems they create, and in the hands of women of exceptional ability, courage, and devotion, and under the better and more generous type of hospital administration, schools of nursing have slowly been brought to a notable point of efficiency. The needs of hospitals have been unfailingly met, and the public provided with an ever-increasing number of nurses of a high level of skill and competence. Moreover, in a good many schools a fine spirit of idealism has prevailed. Time does not permit

me to review the long struggle of these women to build up in their schools a satisfactory system for the education of nurses; to establish suitable standards of fitness for admission; to work out and maintain adequate courses of instruction; to secure funds for the payment of teachers and lecturers; to shorten the hours of duty for students in the hospital; and to reduce for them the burden of unsuitable and educationally unprofitable tasks. I can only repeat that the progress under the conditions has been remarkable.

At the close of its long and searching study, the Committee on Nursing Education, in the most important report ever made on the subject, could only say, "It is a progress made in the face of indifference, negligence, and of active opposition from those who should have been the first to encourage it . . . a progress moving squarely against the vested interests of hospitals long in control of the destinies of nursing education."

A justifiable expedient of early days, in keeping with the conditions and needs of the times, this system has survived for over a half-century, and still lives in an era with which it is strangely out of harmony. In all this long period no change in the position of the nursing school in the hospital has ever been effected. It is still without independent life of its own, without funds, with little freedom to initiate or change educational policies or methods, and burdened with heavy responsibilities and routine duties in the service of the hospital. As the medical director of one of our leading hospitals said to me recently, "The School of Nursing is the backbone of the hospital." To paraphrase Strachey, "The string by which the school is tied is sometimes long, but it is always tied." Confronted with new problems in the education of nurses, whose widening fields of work made new demands upon their knowledge and capacities, our schools have, for the most part, found themselves powerless to make

the necessary readjustment of ideas and methods. An interesting example of this is seen in their efforts to develop an adequate scheme for the preparation of public health nurses.

It has long been recognised that a system so fundamentally wrong in principle should not endure, and for years the subject has been the theme of discussion and controversy. Much has been said to show the necessity of securing for this large, active and rapidly growing profession, freedom to develop its schools in conformity with the changing requirements in an ever-changing world. To those who have given the most serious study to the question, it has become increasingly clear that such freedom could only be gained by separating the school from the hospital, and transforming it into an institution concerned wholly with the education of nurses, and provided with the form of government and resources which would best enable it to carry out that purpose. But the practical advantages of retaining the existing relationship of nursing school to hospital have proved so great, and the practical difficulties in the way of creating and maintaining independent schools have seemed so insurmountable, that progress has been slow.

Nevertheless, progress in this direction has been made. Gradually a new element has entered into the situation which has resulted in a co-operation between schools of nursing and other educational institutions, and has brought to the education of nurses certain necessary resources and facilities which hospitals could not provide.

Early traces of such co-operation appear in the efforts years ago, to secure for student nurses some elementary instruction in the sciences, as a foundation for the later hospital training. The early "Preliminary Courses" were provided in institutions entirely unconnected with hospitals. But the first strong impetus in this direction came from an effort some years ago by a group of superin-

tendents of nursing schools to prepare themselves for their educational responsibilities. Though they were all teaching or directing teaching, few of them had any preparation for such work, and they sought and obtained opportunities for the needed further study, in a well-known college for teachers of a great university.

A few years later another great forward stride was made and a school of nursing was established in an important state university, on the same basis as other professional schools, with the creation of a special degree for its graduates.

These mark the first stages of the new movement in the education of nurses, which has brought it within the realm of university activity and is awakening much general educational interest. It has opened up for nurses the wealth of intellectual opportunity long freely open to students of many other professions and occupations; for those who would be doctors, dentists, pharmacists, for engineers of many types, for teachers, social workers and business men or women. While the movement began in this country, and has reached a stage of considerable importance both in the United States and Canada, it has extended into other countries where certain promising beginnings are being made.

The relationships through which universities and colleges are combining in the education of nurses are of different types, ranging from the independent, endowed nursing schools of which Yale and Western Reserve University afford conspicuous examples, and the endowed graduate department of Teachers' College, Columbia University, to affiliations of various kinds in which nursing schools may gain for their students opportunities to secure through properly equipped teachers, laboratories, libraries, the needed knowledge. These affiliations include not only universities and colleges, but such other educational institutions as may be able to co-operate satisfactorily.

Already the vitalising influence of these new relationships upon the education of nurses are seen in many ways. The most important, of course, appear in the larger number of more highly qualified women entering our schools; they appear further in the whole range, scope and character of the instruction offered; in the larger significance given to the entire scheme of hospital activities, and the new meanings they take on. The conditions of student-training are improved, there is a different kind of supervision; hours of hospital duty for students are shorter, and more graduate nurses are provided to make this possible. It is of the advances in this respect made in a university school that its director can write, "Our school is really supplementary to the nursing staff."

The co-operation of the university with the hospital makes easily possible the opening up of a whole new field of post-graduate training, hitherto educationally undeveloped, in the special branches of nursing in which highly trained workers are so sorely needed.

Finally, and of the utmost importance is the influence exerted on the public mind. People are taking more interest in the educational needs of nurses. All substantial endowments for these have, I believe, been given to schools of nursing connected with universities.

"The task of the university," says Whitehead, "is to weld together imagination and experience." Its combination with the hospital in the education of nurses seems an almost perfect adaptation of that idea, serving at once to strengthen, to energise, to enrich and to deliver it from some of the benumbing effects of continuous routine. We are too near the event to appraise and evaluate truly the changes that are taking place, but what appears to be certain is, that we are in the midst of a liberalising movement in nursing—something destined to set free the mental and

spiritual energies of nurses, and to permit them to flow into new and wider channels of usefulness to human beings, into better care for the sick, better protection of the well, better and more hopeful lives for the nurses themselves.

To the question therefore that may arise, how far can we go in these efforts to add the resources and powers of universities and other educational institutions to the opportunities and experience of the hospital; to obtain for nurses freedom for educational development in their own field of work, I must answer unhesitatingly, just as far as is possible. Believing as I do that universities, and all educational institutions, as well as hospitals, exist for the service of the people, I would see that service furthered by placing schools of nursing among the professional schools of the universities of this country and of other countries as far as existing conditions would make that relationship a practically wise measure.

And I would see it furthered by every effort to enlist the aid of other institutions capable of providing for the training of nurses those essentials which the hospital alone proves unable to supply.

The movement in this direction will set its own limits, but to the application of the principle of freedom in education for which it stands, there are no such limits. And to uphold this principle is quite within the power of most hospitals of such standing as would justify their participation in educational work. It is within their power to work out and establish a different form of organisation for their schools, and a kind of government securing for them freedom for the proper development of every phase of their legitimate work. It is within their power to co-operate in efforts to obtain resources for the conduct of their schools, and to create an informed public opinion on this most important subject. May we not



venture to assure hospitals that they will gain and not lose in such a sharing of power and responsibility?

I am sorry to leave untouched some of the important questions in nursing which must in the future be answered, and will call for exceptional knowledge, ability and courage. The grave problem of unemployment, which is now very serious in many sections, is perhaps the most pressing of these at the moment. But this is in part an outcome of the educational questions which we are considering here.

My discussion this evening has been centered upon one issue—the need for providing for the nursing of the future an educational foundation, of different character from that upon which nursing in the present is built. We lay that foundation when we ensure as far as we are able, that those who follow us shall be women who can bring to the changing problems of the future a good measure of intellectual capacity, and that the schools in which they are trained shall be given freedom and resources

to strengthen and develop such capacities. The need for intelligently educated nurses will not diminish in any future of which we can conceive, but there can be no final conception of the right education for them; this must be a steady evolutionary process.

No one of us knows what the future may hold. It is beyond any reckoning of ours. But living as we do in an era when scientific discovery is transforming the world, when "the elements are changing visibly before our eyes," we can hardly fail to see that nursing so intimately bound up with the deepest necessities of human beings, must share the changes which affect them. The systems, methods and institutions we cherish today may fade and pass, but the developed mind and imagination of future nurses must be equal to the task of creating new ways, new ideas. I know but one foundation upon which the nursing of the future with all its inspiring possibilities can be safely built, and that is the educated minds and spirits of those whose work it will be.

## *The Scientific Method in Social and Health Work*

By N. JULIUS TANDLER, Professor of the University of Vienna; Health and Welfare Commissioner of Vienna, Austria

Social relief and social welfare are modern manifestations of the very ancient human instinct to give help, for the readiness to grant human aid is as old as human civilisation itself. At the outset the granting of individual assistance was based on the law of love of one's neighbour and on religious precepts. The modern tendency towards collective action, a feature of present-day society, has given legislative effect to the will to help, and has led to the adoption of legislative and scientific principles to govern the granting of assistance. What was voluntary has become obligatory and the generous impulse of the individual has given way to regular practice based on exact principles. The whole system of relief in the modern state and in modern economy has become nothing less than a matter of administration in the field of demography. The aim and the object of demography are the management of the organic capital represented by the human beings in a community. If this capital is to be wisely administered, to be preserved, to be in certain circumstances increased and improved in quality—we must apply a system based on economy, more especially on human economy. Instead of the individual act springing from a kind-hearted impulse, we now have an administrative system covering the whole human order and, since to every system of administration exact principles are essential, social care and welfare are strictly derived from exact premises. Logical action is the result of similar premises.

Since, therefore, exact or scientific welfare methods are under discussion I must first of all be permitted to say a few words about welfare itself, that is to say, about organised, practical and economic methods of help. May I be allowed to introduce this subject

by drawing a comparison? One of the oldest and most esteemed branches of social care is that of medical aid. It began by being of a strictly personal character and then its practice became based on tradition and later on science. Medicine in the widest sense of the word is the result of this evolution. Medical science furnishes the principles on which medical aid is based and this science lies in the hands of the medical profession. Science alone, however, does not suffice, for medicine is more than science; it is both an art and a science, so that a doctor is not only a scientist but something of an artist as well. For in every sphere in which man is brought face to face with his fellow-beings the extent of his influence is due not to the amount of his scientific knowledge but to the greatness of his art; for the creative artist is one who awakens the dormant soul of humanity.

The entire scheme of social aid is thus based on exact knowledge, and has in the course of recent years developed along such lines; yet it is something more than a science—it is in fact, like medicine, science combined with art. The welfare expert or social worker, to whatever category he may belong, must, if he is to be efficient, be something of an artist. This necessary combination of qualities explains the fact that so many are called and so few are chosen. Called upon to speak on exact methods in social and welfare work, I must begin by stressing the fact that while such work is grounded on knowledge it is nevertheless artistic in character.

Now, what are these exact premises? They are, firstly, a clear understanding of the social, economic, ethical, educational and medical circumstances which ultimately and finally

make human beings need outside assistance. From the very multiplicity of needs it follows that no single branch of study can be regarded as an end in itself, if the well trained and enlightened expert in social aid is to meet adequately the demands made on him. Social questions are the subject of a particular branch of human knowledge, and social work requires scientific knowledge of purely economic matters. The social worker must, for instance, be acquainted with the trend of the international labour market. He must be versed in the causes of unemployment and the laws governing the unemployment curve. To be an efficient social worker he must know the relation existing between work and wages, and must understand industrial law and labour contracts. Of the utmost importance too is a knowledge of social legislation and it is essential that he should be well versed in that subject. He must understand thoroughly the laws governing unemployment insurance, accident insurance and the whole system of sickness funds. He must know that our modern social work in all its branches is founded on certain definite ethical conceptions. Responsibility on the part not only of those granting assistance but also of those seeking assistance is an essential condition. A proved state of necessity must be morally presupposed, if we desire to keep social welfare from degenerating into ill-advised philanthropy and becoming an instrument for breeding paupers.

Wherever social welfare is applied to the young—and helping young people is not only the most fruitful but also the most difficult branch in the whole scheme of social welfare—a knowledge of education is essential. The problems of the sub-normal child, of juvenile delinquency, of mental deficiency and of congenital physical deformities must be grasped; and finally, intimately connected with this, there is a certain amount of medical knowledge—not, of course,

the pathology and etiology of the different diseases, which are solely and always the business of the medical man. The social worker must, however, understand the social meaning of tuberculosis, alcoholism and venereal diseases. He must be aware of the factors underlying increased or reduced birth and mortality rates, should he wish to take his share in the task of managing the organic or human capital.

It will be seen from these brief references how many scientific data require to be mastered. This does not mean, however, that the social worker should be able to act as Sick Fund or Insurance Society official, as master of a school or to engage in healing and clinical activities as a doctor. Such work must be left, first and last, to officials, teachers and medical men.

It is not, however, the principles of social work alone which must be acquired scientifically; the daily activities of all social workers also must be founded on an exact basis. In accordance with this twofold aspect scientific methods will now be examined. In doing so we shall have to give a few details concerning the various types of social activity.

Every branch of welfare is ultimately and finally, as already stated, nothing more or less than the putting into practice of the science of demography, and this, as has already been said, is nothing more than the administration of an organic capital. The organic capital itself, however, is composed of the human beings of all classes living within a state or community. In every administration we see responsible heads—men and women whose duty it is to carry out the purpose of the organisation in accordance with certain views and within the limits of present legislation, on behalf of the community. They represent, as it were, the spirit of the administration and it is their task to infuse this spirit into the entire organisation.

It is quite another matter with the executive officials whose task it is to carry out orders and who are subordinate to one another. For the leaders of the movement principles are of first importance, and it is prejudicial to leadership when the man at the head of affairs concerns himself with administrative details; on the other hand, the breaking up of the great collective ideas into separate individual functions is the duty of the lower grade members of the administration. To take a simple instance; it will be recognised as a matter of course that the director of a welfare department in a state cannot take a direct interest in the management of a single welfare institution, and it is equally obvious that he cannot interfere with regard to individual social assistance any more than a hospital director or an eminent doctor can be expected to worry about details of nursing technique. Scientific principles should be similarly classified. The head of a welfare department must not only have precise knowledge of the facts of demography, but must share certain definite views on the subject; for there are various currents in this field of study which influence and dominate not only the spirit, but also the practice of social welfare.

May I be allowed to go somewhat more fully into this question, which is important as regards the whole scientific direction of a scheme of social welfare? The question of population politics is as old as civilisation itself, and has fluctuated of course in various districts and at different epochs. Every nation, in the course of its history, has sought to claim the largest possible extent of territory, and has soon been led to the conclusion that such a claim can find support only in mere mass of population. That is why each nation wished to increase its population. When, as we read in the Bible, Jehovah said to the Jews that they would become as numerous as the sands of the sea, the

statement was nothing less than a promise in the field of demography, which has indeed not been fulfilled. The object of this type of population politics is concerned with *quantity*, and I have therefore called it "*quantitative* demography." In modern times, on the other hand, it might properly be called "imperialistic." In quantitative demography the relation between the birth and death rates becomes a matter requiring the most precise scientific analysis, in which all action should take its rise.

Should a population expert believe that the predominant factor is not to be sought in quantity, but in proper living conditions for each member of the community, and in his cultural development, he will direct his attention chiefly to an improvement in *quality* of the human beings for whom he is responsible. I have called this point of view "*qualitative*" and social in contra-distinction to the term "imperialistic."

Here, too, as in every other branch of politics, it is clearly not a question of the opinion or the will of single individuals; prevailing general conditions only count and are of first importance. I should like to quote an instance in support of this. Until the recent war, all European states without exception pursued an imperialistic policy as regards the population question. The number of people, or strictly speaking, the size of the army, was the all-important factor. All efforts were directed towards bringing about an increase in the population. The number of soldiers was calculated for ten and twenty years in advance. At the end of the century a fall in the birth rate occurred throughout almost the whole of Europe and the state of nervous tension resulting from this was undoubtedly partly responsible for the outbreak of the Great War.

The inevitable and progressive fall in the birth rate and the technique of modern warfare, with its masses of mechanical apparatus and war-



machines, have convinced politicians and population experts as well, in all European countries, that the strength of battalions will not be the decisive factor in future warfare. Imperialism still persists in spite of all disarmament conferences, but qualitative demography has gained ground at the expense of the quantitative standard, and we now witness a constantly increasing desire to secure better conditions for the future life of nations—greater care for the young and a conscious effort to influence their general outlook.

These are fundamental principles with which men and women engaged in directing schemes of welfare work must be acquainted if they are to do their business properly. The policy advocated by leaders obviously finds expression in the executive. The continual attempt to persuade women to have as many children as possible has been abandoned; nowadays the policy is to assist all expectant mothers and maternity cases and to devote special care and attention to every child born. The scientific training of child welfare workers is the expression of this policy, and it is perfectly natural that the training of the social worker should also include the management of maternity clinics, the manner in which welfare centres for mothers should be conducted and the importance of behaviour clinics, and so on. It is easy to understand why schools of social work now lay special emphasis on the teaching of these subjects.

The individual has gained enormously in value; the general interest has become focussed on his care and his maintenance. However paradoxical it may sound, the war has, by cheapening human life, raised its value. With a view to applying these scientific principles to the different branches of social work, a whole series of schools, formerly quite unknown, has come into being, e.g., schools of social work, schools of nursing, for kindergarten teachers, and so on. In

all of them the fundamental scientific principles of social work are taught in a thousand ways and with very varying methods.

The increased value of human life has also led to widespread campaigns against diseases which had long been recognised as the social scourges of civilisation—all the more so since epidemics of acute infectious diseases have been almost entirely stamped out. This explains the increased attention at present devoted to the fight against alcoholism, tuberculosis and venereal diseases. In this field also medical knowledge alone is inadequate, for these three social scourges are important rather on account of their social-political aspects. Centres for combating drink, venereal disease and tuberculosis require a staff of social workers, who in their turn must be trained on scientific lines.

As already stated, science is of fundamental importance not only in the training of welfare workers but in the exercise of their daily duties. Careful observation of economic and political conditions will never cease to influence the opinions and activities of those who direct the welfare movement in the different countries.

It is quite another matter in the case of the individual executive. He will indeed feel the reactions of important events, although their logical causes are unknown to him; yet in spite of this, every step the social worker takes has, or at any rate should have, some scientific reason. I should like to illustrate this point also by a few examples. Every kind of social relief, whether on behalf of the aged or the young, must inevitably develop into family relief. The family is and remains not only the biological germinating cell of the social body, but is also the cell of this body to which we are constantly forced to devote our attention. When, therefore, a child welfare worker has, for some reason or other, to undertake the care of a child, such a case is not in itself one of poverty or misfor-

tune, but is merely an indication of family poverty or misfortune; thus it becomes the duty of the welfare worker to look after the whole family. Here the scientific method begins with the study of the case history, which must precede case diagnosis. Case history must also start on a scientific basis if a cure is to be effected. The mere inquiry into case history, the questions put to the persons concerned, involve knowledge of a series of different subjects. Each question and each answer must serve a definite technical purpose. Each question, therefore, must be psychologically clear if the answer is to be socially true. Case diagnosis rests on logical conclusions drawn from premises established by case history.

For this purpose, the social worker must not only have the gift of observation, he must also have a large amount of theoretical knowledge, which must, if needs be, find practical application. To recognise unemployment as the cause of family poverty is very easy, but to differentiate distaste for work from lack of work is often very difficult. The problem becomes much more complex when material difficulties are enhanced by those of a psychological nature. Incompatibility of temperament in parents is far oftener the root cause of difficulty in the upbringing of children than any innate anti-social instincts in the children themselves. Here it is often not at all easy to differentiate between the faults of the parents and those of the children. Many cases of child neglect become at once easy to diagnose when antagonism between the parents based on erotic or sexual causes can be brought to light.

The same remarks apply to all forms of "cure." This should, as far as possible, be etiological and aim therefore at removing the cause of the evil. A cause such as the unemployment of the father of a family may prove under certain circumstances very difficult to deal with. Re-

lations with unemployment centres or labour exchanges are essential in this case, and that is why it becomes necessary for the welfare worker to understand, to a certain extent, the trend of the labour market. She must notice present crises in the labour market so that she may direct the father to the right quarter. Procuring employment for the head of the family is the obvious and normal step, but one which it is at present often impossible to take. It represents, if you choose, the real and proper "cure."

Unemployment must also be treated in other ways. By placing a young child in a kindergarten or home during the day, the welfare worker can often enable the mother to save and maintain the family by her earnings. For this purpose also some special knowledge is required. In another case, the placing of a sick child in a nursing home or the help of a sickness fund may relieve the family burden and increase the mother's chances of finding work. The welfare worker must therefore know at any rate the simplest facts concerning sickness insurance and sickness funds if she is to succeed in effecting her "cures."

Thus every step taken by a welfare worker in a case of this kind is seen to be grounded on scientific principles. The cases referred to above are of frequent occurrence, but are still comparatively simple ones. Much harder to solve are those cases of difficult children combined with parental drunkenness, and so on. The welfare worker who looks after a child becomes finally the confidant of the family and should, in all situations and circumstances, stand by the side of the family as adviser and helper. The innumerable complications of modern life make constant demands on the exact knowledge of such a confidant.

We have up to the present discussed child welfare workers, and will now review in brief the duties of the

worker in another field of welfare activities. In earlier times it was invariably the mother's duty to rear and educate her baby. She may or may not have been a suitable person for the purpose. The greatly increased strain thrown on the individual by modern civilisation and present economic circumstances have often revealed the incapacity of the mother to fill her part. Years ago men like Pestalozzi and Frôbel recognised this individual inability and gathered children about them, seeking to educate them in kindergartens. The system has been extended and there has arisen not only the psychology of childhood but, as a logical consequence, an educational system wholly confined to the small child. The idea has become generally known and kindergartens have been established in which infants are educated in obedience to various methods. To quote an instance: The town of Vienna has today over 100 kindergartens, in which more than 8,000 children are looked after daily. The profession of kindergarten teacher has gradually become an independent career. The teachers not only receive a three years' training course, but they are also obliged to draw upon their scientific knowledge in the course of their daily work. Their activities must obey the leading principles of child hygiene. The psychology of childhood is the chief theme of their duties; when we realise what momentous impressions, influencing the whole of adult life, are connected with just this period of early childhood, we shall readily grasp the significance of the teacher's influence. In this field psychological knowledge and educational experience are decisively valuable; here too scientifically directed methods are of vital importance.

The multiplicity of postulates of a scientific character which must be mastered are conducive to specialisation in some branch of social relief. Thus in the field of social welfare there is an increasing tendency for

workers to specialise. Complaints are now being raised on all sides against specialisation in medical work, and they will, at a not distant date, be equally applicable to specialisation in the field of social welfare work. Such specialisation cannot, however, be avoided. Everyone who has been engaged in welfare work of a responsible nature for any length of time must be perfectly aware of this, and I can confirm it from my personal experience.

Medical assistance, being the oldest type of welfare work, developed early. Thus we see, in the international field, the nursing profession put on a progressively scientific basis, and practised in an increasingly scientific manner. The considerable body of nurses of the present day constitutes one of the mainstays of our whole scheme of social welfare. The progress in this sphere of welfare work is really admirable, if only on account of the speed with which it is being achieved. I can remember from my medical student days, how we looked on the nurses as ignorant women, totally unacquainted with the simplest facts of medical care; they seemed to come straight from the street into the sick room, seeking employment and a livelihood. They brought to the task mere readiness to help and nothing more. Comparison with the scientific and thorough training of the present-day nurses, as provided in the different schools, will afford some idea of the immense progress achieved. To-day the nurse is a real helper of the sick, on whom doctor and patient alike can rely. To readiness to help has been added capacity to help, to qualities of heart those of brain. Here we see the scientific method in its most perfect form; here daily progress is being made. Unthinking tradition has been replaced by action based on knowledge. Medical progress has become the daily teacher of the nurse. A mere occupation has been transformed into an art.

Progress in other spheres of human relief work has been very much slower, perhaps on account of the fact that the movement is of much more recent date. Man learned early to care for the sick, but was late in seizing the fact that help was also required for the healthy suffering from social deficiency. What the nurse is to the physically or mentally diseased, the welfare or social worker is to the socially sick. In this sphere also, assistance consciously based on economic principles has replaced mere relief work, and social workers acquire their knowledge of the subject by study; they are trained in schools which teach them the basic principles of economics and of the social edifice in all its parts.

In this field, too, mass training has replaced individual experiment. And here, again, the demands of specialised social welfare have resulted in the creation of specialists. Nurses for surgical cases are distinguished from those who have studied dietetics, and also from x-ray sisters and sisters in children's hospitals. The same is true in welfare work; child welfare, school nursing and co-operation in the campaign against alcoholism are some of the branches which have developed. They have all justified their existence and have become a need. None the less, wider aspects must not be lost sight of or neglected. Scientific prin-

ciples may be different, technique may vary, but the fundamental conception remains everywhere the same. Social workers are but the different organs of one large body; they are collectively the executive organ of demographical policy. Each has his special scientific method and uses a scientific technique in accordance with his particular task. The scientific nature of the principles which find their expression in methods of training, in the transition from tradition to teaching, yields a possibility of success—but one possibility only.

The other possibility lies in personality and cannot therefore be learned; it is seen in the art of awakening the human soul, of winning confidence, granting spiritual aid and finally consolation. A nurse is more than a healing machine, a social worker more than a lifeless tool for social aid. They all have souls, since they are human beings. Exact training and scientific equipment may be intensified and increased, yet the limit set to all social aid is and remains in each particular case the personality of the social worker. Nurses and welfare workers of all classes are right to demand improved scientific instruction and preparation. That is what they receive; what they must give in exchange is their strength of soul, and the incarnation of all human aid—the spirit of charity.



*The Nurse as a Citizen*

By BERTHA WELLIN.

Member of Swedish Parliament, President of Swedish Nurses' Association

The democratic developments of today have entailed that citizens of a modern state with universal suffrage—men and women alike—when they have attained voting age, not only answer the personal call to action as adult individuals but also fulfil their duty as citizens. This can be done by using their influence as voters at public elections of various kinds, and by placing themselves, when called upon to do so, at the disposal of the public as candidates at such elections, with all the consequences that this entails.

The use of the vote should not be looked upon by the citizen as a privilege which he may use if he so wishes, but as a duty from which he should not try to escape unless he has very urgent reasons. The execution of this duty demands certain qualifications. To begin with, of course, the voter should study and make himself familiar with the technical ways and means of voting and, what is more important, he must clearly and positively understand not only for whom he is voting, but also for what he is voting and in which direction his ballot-paper is likely to influence developments.

This requires of each person entitled to vote certain insight and discernment with regard to public questions, cultural and social as well as political. The accepting of a candidature and the filling of a public position of trust demand a closer knowledge of the subject and more sharply defined and clearer lines as regards the personal conception, as well as a capacity to explain and defend these both verbally and in writing.

The general points of view expressed here apply to all citizens possessing a vote, and therefore include nurses. A more careful consideration of the problem of "The Nurse as a Citizen," however, shows that her position is

more complicated and delicate than that of the majority of citizens, especially when it is a question of a more active part in political life.

The nurse's position and work, both as regards the care of the sick and in the more social fields of labour, are essentially intermediary and therefore of a particularly exacting and delicate nature. It is not easy to combine such an intermediary position with the active and prominent work of a politician. A combination of these two tasks will of necessity make the nurse's position still more delicate, and can easily produce friction of various kinds.

It is clear that although a nurse can devote herself, even actively, to political work, the various nurses associations must adhere to the necessity for neutrality, so that the associations remain above political strife. Any other line of action would necessarily jeopardise peace and unity in an organisation, and would undoubtedly upset general faith in its activities.

We must therefore leave the associations aside and concern ourselves only with the nurse as an individual, and then not as an active politician, but as an interested citizen.

It is an indisputable fact that the sickroom and the hospital ward should not be places of political propaganda for one particular party or another. But positive and illuminating discussions on political and other questions of general interest need not be excluded when circumstances appear suitable for them. They can perhaps contribute to awaken public spirit and a feeling of responsibility in many who were previously not interested.

Opportunities for social work outside the hospitals are manifold. Much can be done quietly, from the Christian cultural and social points of view, during the daily work. Even from

the purely political point of view, I venture to suggest that a great deal can be gained, without agitation, not least by the raising of standards, by a cleansing process of tone and spirit and by the opposing of bitterness among political adversaries. Whether we call them democrats and conservatives, labourers and employers, republicans and monarchists, is of minor importance. The essential factors are the different ways of thinking and understanding. It is an entirely loyal and natural endeavour that each group seeks to have as large an influence as possible by means of an increased spreading of its ideas, and by winning a steadily increasing number of voters for its party. With goodwill on all sides, this should take place without debasement and poisoning of tone, and with a retaining of mutual respect among those of differing opinions. That this should be the case is of vital public interest and of the greatest importance to all good citizens.

We may, therefore, take it for granted that a nurse who thus understands her citizenship will be able to work with success and pleasure with others, even with those of other opinions than her own, without the political interest she displays having a retarding influence on her labours.

For the nurse who takes an active part in public health, there are daily opportunities of coming into touch with circumstances dependent upon public administration. Here we meet public education with its enormous influence on children and young people, insurance against sickness and accidents, pensions and old age insurance, and many other social benefits for citizens of all ages and classes. In her work a nurse can gain much experience and, in many cases, obtain a good idea of laws and measures adopted by the authorities when these become effective in public life. Observations thus acquired may later, in a direct and practical manner, become productive if the nurse is elected into some municipal body which decides upon and leads such

activities. Skilled and tactful work on her part, as a member of a board, will not be without result in the long run, especially if combined with the same qualities in the personal sphere of labour she has been called upon to take up in the community.

A municipal election is generally fought on political lines and it is indisputable that the party limits thereof will be sharply pronounced. What the individual citizen can do is to keep his own conscience sensitive, to listen to its voice, and to do his best to make the positive points of view overrule those of a purely party-political kind. If this conception is combined with a feeling of public spirit and with a living patriotism, the result should be useful work to the good of human progress within the community. But it cannot be denied that the present pronounced party system to a certain degree constitutes a restraint on the individual. This cannot be looked upon as only an evil restraint however. On the contrary, it is, like many other things, a phenomenon of both good and evil. The result will be entirely dependent upon how the restraint is employed. It can be abused, when it will be harmful; it can, on the other hand, be necessary to prevent injurious and individually arbitrary ideas and measures. A certain degree of discipline is, as a rule, useful to human society. All depends upon a party having leaders who are wise, tactful and conscious of their responsibility.

There are those who only see the wrong side of the party system. They sometimes combat party formations, even by forming coalitions, i.e. combinations with other parties—consequently quite a homeopathic cure, a reaction against the party system by the formation of another party. A strange phenomenon of this kind is a group supporting a list of women only at an election, a party formation on sex lines, instead of according to opinions. A political formation of parties of women against men is one of the least successful and

has very limited possibilities of development, because most women will probably invariably refuse to give their adherence to it. A more practical and certainly a more practicable way to win a legitimate influence is for women within the various parties to work to advance their own candidate on the party list in harmony with the men. By such a procedure women preserve for themselves the possibility of influencing the list in its entirety.

When speaking of the nurse as a citizen it is easy to pass from this wider sphere into the narrower circle in which the nurse moves when doing the work to which she has been called. To do so need not mean the putting aside of a question at issue, but is rather only a deepening thereof, because our personal work and our individual task in the community, and the manner in which we fulfil and understand these, constitute the foundation upon which our part in citizenship is built—the soil wherein it must grow.

When accepted as a student the young woman's responsibility for her actions becomes widened, and this is even more so when her training is concluded and she is accepted as a nurse. In both these cases the public will, in many ways, criticise the schools for nurses and the institutions according to the manner in which their private members appear and act. During the whole of our activity as nurses we must, whether we wish to or not, exercise an influence upon the opinion people hold of the school of nursing which has trained us, and upon the organisation to which we belong—its good name and reputation. The organisation gets a good or bad reputation according to our actions.

At the beginning this intimate connection between the individual and the institution was even more sharply pronounced, as, for instance, in the Catholic nursing orders and, later, in the Evangelical motherhouses. Affinity, therefore, has its roots far back in the ages, and it is closely

allied to the old system of orders which were centres for those who volunteered for certain sacrifices and, of their own free will, undertook certain duties.

It became a question of honour for all members of the order to uphold its principles and translate these into practice. So long as the members were united their order flourished and exercised a useful and beneficial influence, but when members became lax in the fulfilment of their duty and their feeling of responsibility, the order began to decline or even break up. If we look back upon historical development in philanthropic work, which is the predecessor of the present day system for the care of the sick and other social work, we find everywhere co-operation based on a feeling of community, which makes members dependent upon one another, not only in their work but also in private life. We may learn from this that one cannot here isolate one's work from private life. Personality is intimately bound up with the mission in life. In modern times motherhouses replace the old orders of mercy and, in part, the Catholic monastic orders. Both in the Catholic orders which still care for the sick, and in the Evangelical motherhouses, the principle of certain personal obligations and certain liabilities, the following of certain definite rules and unity in a common institution, have been retained. This becomes inevitable in a systematically arranged organisation. Rules and regulations must, naturally, change in course of time, but they must exist, together with the will to be united and a spirit which has the power to influence private members towards sacrifice and unselfishness. All collective work presupposes a certain amount of self-denial.

As the old orders had to give way to newer organisations, the motherhouses have in part had to make way for more modern co-operations possessing a more independent position for the individual. But success is dependent upon unity, the strength of which is dependent upon the

feeling of responsibility of the individual members. Progress in our times has gradually taken the direction in which the nurse attends to her own affairs. This is strikingly manifested by the existence of the many different kinds of nurses' associations, the national federations, and by the International Council of Nurses. However, the fact still remains that even these associations must, if progress and success are to be achieved, build upon internal unity and a feeling of responsibility, together with the loyalty of individual members.

I have already said that we are responsible to the corps, i.e. to our colleagues, and not only our class colleagues and those who belong to the same organisation, but to the nurses of the whole country. But does the responsibility stop even there? By no means; our responsibility applies to today, but also to the past and the future. We cannot isolate ourselves and our work, and cannot look upon our work as a private matter. Around us are figures of the past, as well as of the present, and before us we may glimpse coming generations who will have to reap the harvest we have sown, and who will one day take over our task. No, of a certainty we may not isolate ourselves or our work. And as a symbol of this all-embracing communion we have, in the first place, the organisation which has received us and counts us as members of its nurses' group.

There is something else which accompanies co-operation—the growth in importance of the individual's task. It is true that we all, even if we stand alone, have a large responsibility for the tasks we accomplish in the progress of humanity, but the work of the individual may easily be lost—its traces disappear more easily than if his work is embodied in an enduring organisation, within which the many energies become joined in one united power, the effect of which is apparent for decades

or perhaps for centuries. Responsibility increases in proportion to the power and influence of an organisation.

It may of course be remarked that an organisation of the kind should in itself be so strong that it cannot be harmed if one or another of its members does not give satisfaction or deviates more or less from its fundamental conceptions and rules. And luckily the good is in itself so strong that it can stand much; but such discussion is both insidious and dangerous because we humans can but partly follow the consequences of our actions or foretell the results thereof.

It is a privilege and a personal distinction to belong to a respected organisation, because a member is looked upon with confidence and respect, a confidence so great that the organisation is prepared to place its public reputation in the hands of the member, as well as the judgment of itself before history. This, and no less, is placed in the hands of the nurse when she becomes the member of an organisation. This is something to remember and take to heart. It cannot, therefore, ever be asserted that the life and work of the nurse, even her private life, are solely her own personal affair.

The dutiful nurse with a feeling of responsibility can comparatively easily understand, therefore, how to subordinate herself to her responsibilities as a citizen, because she is already in her private actions a noble member of the community. She need only extend the limits of her interests and responsibilities, and her thirst for knowledge and devotion—and she becomes, in the best sense, a useful and active citizen. If the nurse adopts this enlarged task, with the ideals and sound traditions, with the feelings of responsibility and faith which have given her her respected place in therapeutics, then she will also within this larger sphere perform a useful and valuable task in the service of human progress.



## *Exchange Scholarships*

By ALICE LLOYD STILL, Matron, St. Thomas's Hospital, London

I have had the honour of being invited to present to you a paper on the subject of Exchange Scholarships. I am not covering familiar ground and therefore have had recourse to the established work of the Rockefeller Foundation, the data of which I owe to the kindness of Miss Crowell. I plead for your patience while I place before you, as I am bound to do, much that is still problematical.

Exchange scholarships, if understood as interchange of scholars on equal terms between the nursing schools of different countries, do not yet exist; but for several years scholarships or fellowships have been granted to nurses by such educational bodies as the Rockefeller Foundation, the various Red Cross Societies under the auspices of the League of Red Cross Societies, aided by State Educational or Health Departments, and from time to time by an individual nursing school. These scholarships have usually been provided for extended study in public health, but some have been given for the purpose of studying nursing methods, so that advances may be made in those countries where the nursing service is still inadequate, or that good knowledge and well-trained capacity may be enriched by a wider vision and a fresh outlook.

These scholarships have been more comprehensively developed by the Rockefeller Foundation than by the other bodies mentioned; therefore I shall first sketch its aims and methods, so that I may put a clear issue before you.

The work of the Rockefeller Foundation is well known to all present. While its influence and financial aid have been devoted chiefly to the furtherance of medical education and of public health activities, it has not failed to realise that nursing education frequently constitutes an important factor in the successful accomplishment of projects in these two fields.

Nursing education all over the world, and especially in Europe, has derived

much benefit from the Foundation in the form of fellowships that give the Nurse Fellows opportunities of study in other countries. Their choice of field naturally depends upon the purpose for which the fellowship has been awarded.

The aim of such fellowships is largely two-fold:

1. To give fresh impetus and renewed vigour to those who have been long in harness and become worn-out and stale, and to render them more sympathetic to the introduction of new modern methods by younger specially-trained assistants.

2. To supply post-graduate study and the best facilities for practical experience to those who desire to fit themselves for specialised work, e.g., dietetics, pediatric nursing, public health work.

In the first case, a suitable change of environment with the new contacts that result, will bring the needed recreation, and the choice of a particular field is of secondary importance.

In the second case, the best field must be selected for the specialised study; one that not only provides the experience, but will fully supply the necessary teaching on the subject and efficiently handle the educational problems involved.

The Nurse Fellow should remain long enough to acquire the technique in use by actual participation in the work.

The choice must also take account of the future position for which the candidate is being prepared, and the limitations imposed by language, temperament and racial psychology.

The Rockefeller Foundation have unique opportunities for seeking the possibilities and appraising the values of the fields of experience provided by the countries of the Old and New Worlds. England, France, Belgium and Austria are largely used to supply experience in bedside and ward nursing, midwifery, infant care, child welfare and specialised public health nursing.

America has been used for the type of experience essential to directors and teachers in schools of nursing and for those studying generalised public health services.

The policy of the Rockefeller Foundation is to prepare Nurse Fellows for definite posts which await the completion of their fellowship training.

**SUPERVISION OF FOREIGN FELLOWS.** That full advantage may be taken of these fellowships, it is advisable that someone who knows the two countries well should be available to interpret the student to the field and the field to the student.

**SELECTION OF CANDIDATES.**—Certain qualities and qualifications must be possessed by the candidate.

1. She must be of good education, with powers of expression, in order to obtain the best value from the theoretical instruction.

2. She must have had sufficient experience in ward and administrative practice to supply a groundwork for a full appreciation of new material and its suitable adaptation; also knowledge of general work conditions in her own country.

3. She must exercise selective judgment and be able to criticise constructively.

4. She must bring to her new outlook the best professional training her country has to offer, and be familiar with training conditions at home.

Of similar nature, but within a more defined range, is the work of the League of Red Cross Societies, which, under the control of its Nursing Division, has organised courses of theoretical and practical instruction in public health nursing and training school administration for students selected by the Red Cross or State educational bodies of the different countries with which the League is in close co-operation. These courses are, at present, taken at Bedford College for Women, University of London, supplemented by the Education Department of the College of Nursing, which also arranges for any practical experience required, and it is most inspiring to see the enthusiasm of the nurses, the courage

with which they face and overcome the difficulties of language and strange environment; the excellent grasp they obtain of the comprehensive material supplied for their instruction. The daughters of Asia make common cause and cement life-long friendships with the daughters of Europe and America; and in this we see one of the most fruitful results of these scholarships—the furtherance of World Peace, in a closer understanding and in the unity of common purpose.

Machinery exists for exchange of professors between the universities of different countries, but we have yet to formulate a scheme of Exchange Scholarships for nurses. These scholarships can, therefore, only be discussed problematically as regards their programme, their advantages, the difficulties to be encountered.

Such a scholarship should be given to the graduate or trained nurse, and one of the type already described, so that she can derive full benefit and bring back to her school or field of work the best that can be culled from her fresh experiences. An interchange between two schools of the same grade in different countries, even after the short period of three years' training, would be much to the advantage of the individual nurses, though it is doubtful if either could contribute much to her particular field. Naturally the financing of such an exchange would have to come from an independent fund and by individual arrangement, and therefore hardly comes within this survey.

Given a suitable candidate she should be allowed to profit by visiting all departments—nursing, administrative, educational—for a sufficient length of time for her to be able to grasp the actual working of each.

The reciprocating Nurse Fellow should be given the same opportunities. Each should be able to make unbiassed reports of her experience, and to offer constructive criticism. Both these reports should be in the hands of the authorities of the reciprocating hospitals; otherwise the exchange would not fulfil its purpose.

Such an exchange can only be of value to a school if the representative be of the right type—a woman of good education and social standing, well-grounded in the theory and practice of nursing, with adequate experience in administration and a fair working knowledge of the educational programme of nursing schools in her own country. In addition she must possess tact, an open mind, a sense of proportion and the power to adapt herself to new conditions—all of which will prevent that hypercritical outlook that is liable to detract very seriously from the value of the interchange and may only serve to rouse antagonism where greater sympathy and understanding are of the first importance.

All this experience is wasted unless the individual chosen possesses sufficient force of character, position and standing in her mother school to secure that her contribution be fully acceptable to that school.

There are difficulties to be encountered in planning and launching such a scheme. Finance is the first problem. It is obvious that for the first three months the Nurse Fellow is of little economic value to the hospital and its nursing service. Regarded as a unit, she may even be the cause of loss from the educational, practical and administrative points of view. Very few nurse training schools possess a budget independent of the hospital finance. Therefore permission for such interchange must come from hospital authorities. Here one might stress the advantage of a separate budget for nurse training schools. Miss Nightingale was wise before her time when she allocated funds to support a nursing school, but she also formed a Council, reserving to them the right of directing the education of its pupils—the hospital finding the plant, i.e., the equipment and field of experience.

Again we must remember that each race or country will have its own peculiar needs, will make its own specific demands and will establish habits, methods, rules and regulations in response to such and in obedience to the urge of its own racial psychology.

In this way the exchange may only serve the individual by giving her greater interest and wider outlook, but it may not provide her with any concrete material with which to enrich her school; yet the friendly interchange cannot be judged as valueless.

Individuality in nursing developments must be maintained at all costs in the different countries. Each must work according to its own national genius, though the same spirit of service may inspire all alike, and all may be striving after the same ideals.

Climate, temperament, inheritance, all combine to make a blend that gives a country its own peculiar atmosphere, which, if allowed to permeate the living body, saves method and organisation from being that lifeless machine which kills spirit and initiative.

We must be alive to the danger of standardising too rigidly the nursing programmes of the various countries. Free development along national lines is surely the ideal to be followed.

Again, grave responsibility is assumed in distributing trust moneys. These scholarships are luxuries. The nursing profession is tending to develop in luxury and to lose thereby the creative genius that finds expression when necessity drives. Striving must be stimulated by necessity; easy getting deadens initiative. Luxurious training does not tend to self-denial, nor does it foster the spirit of service, without which nursing becomes a mere profession and forfeits its high calling as a vocation.

If the consensus of opinion decides that these exchange scholarships between individual nursing schools are essential to new life and fresh vigour, then there should be no insuperable difficulty in obtaining them. Whether they should be given in one or two isolated cases, or be available in large numbers is another matter to be considered. But never let a question of finance thwart us in the development of what is necessary. Do not, however, be depressed over slow progress, because he who builds slowly builds soundly and makes his foundations sure.

*University Schools of Nursing*

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Retrospectively considered, nursing falls into three rather clearly-defined periods, which in the cause of brevity I shall designate as the emotional, the technical and the creative, each successive period sublimating the intrinsic values of the preceding to produce a finer and fuller expression of this pre-eminent woman's part in the stupendous drama called life.

Fortunate it is that the history of nursing is not only already available through more than one historian, but that the subject now finds so universal a place in the curriculum as to avert the necessity of the usual historical setting—the first period so imaginatively intriguing with its crudities mellowed by age and its suffering transmuted into beauty through the pageantry of a colourful past. The second period with its long arid stretches of unrelenting toil that boldly and persistently attacked at their base the sores of humanity and laid the foundation for the present dynamic programme—a vivid conception of both imperative to grasp in any measure the significance or implication of the development of the third, which I have ventured to designate as the creative period, and the key note of which is expressed in the title of this paper.

The processes through which nursing education may or will proceed in other countries it is not the part of this paper to portray. I can only venture to present, and that in merest outline, the educational trend in the United States of a profession which is at the moment a strategic branch of the ever expanding health forces and an entirely consistent expression of emerging womanhood in a political state designated as a democracy and thereby committed to the application for the best ends of the people all available goods, a commitment which

implies, for reasons too obvious to rehearse to an audience such as this, the fullest possible knowledge by women of the findings of science bearing upon nature and pre-eminent human nature.

*Educational Opportunities*

However failing the United States may be in her interpretation of the demands imposed by a democratic state, she has not failed in opening the windows of educational opportunity to her children, nor have the children failed to respond.

The creation of state universities, implicit in which is the provision for the development of any individual to his highest capacity, the almost phenomenal increase in student enrollment are indisputable evidence of educational opportunity, however open to criticism such generous provision and eager response may be.

In 1926 the number of colleges listed by the Bureau of Education in Washington was 744. In approximately 62 of these institutions may be found some connection with a school or department of nursing. These connections, however, present the entire gamut of educational co-operation, from the use of a class room or laboratory for the provision of instruction in one or more subjects to a fully recognised school of the university group. Correct orientation in considering the subject before us demands at least a brief restatement of the steps by which this development that marks the third, and an epochal, period of nursing history has been reached.

If 1860 saw through the creation of St. Thomas's School, London, the establishment of the first educational programme of nursing, and 1873 the first schools of nursing in the United States, history ascribes the first attempt to establish the university relationship to the year 1893 when



the Royal Infirmary in Glasgow required of the students entering the school preliminary instruction in the sciences in St. Mungo's Medical College, under the usual university requirement of the payment of tuition fees, examination, etc.

In the United States the connection appears to have been first achieved through the initiative of Miss McMillan by the Presbyterian Hospital School of Nursing in Chicago with the Rush Medical College in 1903, while to Dr. Richard Olding Beard, professor of physiological chemistry in the University of Minnesota, the profession must always be indebted for the establishment in 1910 of the first school of nursing on a recognised university basis.

As is well known, in 1907 through the efforts of the early leaders in nursing education, pre-eminently Isabel Hampton Robb and Adelaide Nutting, James E. Russell, dean of the then recently opened Teachers' College of Columbia University, established some courses in hospital economics. These courses led in 1910 to an endowment by Mrs. Helen Hartly Jenkins, a trustee of Teachers' College, which made possible the creation of a department of nursing and health, the first provision for graduate courses for administrators and teachers of nursing and the various branches of public health nursing in the world. Under the able leadership of M. Adelaide Nutting, the influence of this department has extended from continent to continent, strengthening the courses in nursing and establishing connection with university after university, thereby returning in some measure the contributions of England's great leader to the nursing care of the sick on this continent.

Of these one must mention the several universities in Canada: McGill and the University of Montreal, the Universities of Toronto, British Columbia, Alberta, and Western University, London; in England the notable graduate work at Bedford

College and the course at Leeds University; in China the schools connected with Peking Medical School and the Yale-in-China Medical School (or Yali); in Japan the recently established relationship of St. Luke's to the University of Tokyo; in New Zealand and Australia we understand university schools are in the making.

Through the entrance of a group qualified as teachers and administrators into the field of nursing education, the paucity and wide variations of the curricula were increasingly revealed, with the eventual result that the Rockefeller Foundation, deeply interested in health as the foundation of social and economic efficiency, and recognising the nurse as an important factor in any health plan, assigned in 1922 an appropriation for a study, and the first, of nursing education, which was made by Josephine Goldmark, well known as the author of "Fatigue and Efficiency," under the advice of a committee of experts in the fields of medicine, nursing and hospital administration, of which Professor C. E. A. Winslow, of Yale University, was chairman. The report based on a survey of a selected group of schools administered by hospitals of recognised standing, revealed the deleterious effect upon nursing of the subordination of the students' programme of education to the needs of the hospital service.

If this Study of Nursing and Nursing Education in the United States published ten years ago revealed the failure of the apprenticeship method to prepare the nurse for present day needs of either preventive or curative medicine, the first and very recently published report of the grading committee entitled "Nurses, Patients and Pocketbooks," presents a picture of over production and faulty distribution, and indicates clearly the importance of emphasis on quality rather than on quantity in preparing women for the nursing field.

To the soundness of the conclusions reached by this representative and now famous committee, the 1928 report of the schools of nursing registered under the New York State Education Department bears ample, even tragic testimony. For while in the past three years, 1926, 1927, 1928, there has been an appreciable increase in the percentage of high school graduates entering these schools, from 36 per cent. to 42 per cent., approximately 3,981 students enrolling in 1928, the percentage with college preparation has remained steadily at eight-tenths of one per cent., with the enrollment of women in the colleges of New York State alone reported for the year 1926 as 36,568, or a greater number than enrolled in the entire country in 1890.

In short, for the past twenty years we have so persistently subscribed to quantity not quality that nursing that has barely, if indeed has yet, achieved adolescence, stands facing over production and unpreparedness—over production which means economic insecurity for a group of workers whose physical output, for their professional or vocational preparation and contribution, can not be challenged; and unprepared for function in fields pre-eminently ours.

The so-called university movement is therefore very timely. It has been asserted that what determined economic organisation was not national genius but social necessity. The evolution of nursing makes no exception to this rule. Social necessity certainly created nursing and is now forcing the changes which we are seeking to effect through the university relationship. Upon the nursing profession must and should fall the problem of safe-guarding and perpetuating the best traditions of the profession while formulating a programme through which its achievement may keep step with the progress in the medical and other sciences. This is in effect to demand a programme of education through which the community may be ensured the

nursing service required in the curative and remedial incidence of disease and the many means now available for its prevention.

### *The University School*

What do we understand by a university school? A university school, in a real sense of the term, demands the following:

1st: An established and recognised status: That is to say a school admitted to all the rights and privileges accorded the other schools and colleges of any given university.

2nd: The resources accepted as essential for the creation, maintenance and future development of an educational activity of professional grade, and in addition the resources demanded by the special nature of any given professional activity.

3rd: A qualified student body.

The entire paper might well be devoted to an elaboration and discussion of any one of these essentials topically considered, with another period allocated to the social returns predictable from such a professional foundation and social expression. I propose to consider as briefly as possible the second and third of these essentials as fundamental to the achievement of the first.

### *Resources*

This item obviously falls into two major divisions, financial and educational, with many minor but perplexingly interrelated divisions. So clear an exposition of the necessity of a sound economic basis for schools of nursing has been presented by Miss Nutting, and so widely has it been read and quoted, that one need hardly raise the argument, except to again call attention to the fact that education has always had to be subsidised, either by state grants, taxes or gifts.

From the founding of the Nightingale School at St. Thomas's in 1860 through the first known endowment of nursing education, and the endowments, small in amount, of the first two or three schools to come into existence in this country in 1873, nursing education has not commanded the subsidies other branches of

professional and vocational education have been able to secure. Contributions there have been of importance—mainly taking the form of residential facilities, generally comfortable, often very attractive, and frequently included in these domiciles were some of the needed teaching facilities, but not until the gift of Mrs. H. H. Jenkins that brought into existence the first graduate department of nursing education was *nursing education* as such subsidised. This opened a new chapter in the history of nursing, for it immeasurably forwarded new and broader concepts of the undergraduate course—concepts that the great gifts of Mrs. Bolton and her family for the Western Reserve University School and of the Rockefeller Foundation to Yale University for its school of nursing are making possible to put into effect. Only through endowments will the provision of an adequate and qualified faculty, and the required teaching and residential facilities be ensured.

An important question in the matter of resources is the comparison of the per student cost in the school of nursing with that of other schools of the university. Here we are plunged into an exceedingly complex problem, because of the relationship of the school of nursing through both faculty and students to a business, and one of a most difficult and delicate nature—furthermore, one that offers no return but rather demands an output from its stockholders, while to the consumer who wants none of it but upon whom it is forced, the output is costly and the returns unpredictable.

It is possibly of interest that the income from the recent munificent gift to the Yale School of Nursing by the Rockefeller Foundation of one million dollars, together with the tuition fees of the students, barely suffice to carry the overhead of nursing education. The cost per student to the university, however, when we include, as we should, the students from the affiliating schools (approx-

mately 100), compares more than favourably with the per capita cost in other schools in the university—it presents in fact the lowest per capita cost per year. Nevertheless, the cost of nursing service to the New Haven Hospital, with which the school is affiliated, is fully as great if not greater than that of other institutions that assume the full cost of nursing education.

The problem of adequate hospital support is a burning one and bears very directly upon the question of the cost of nursing education. Several studies are now in progress which will be of great value in ascertaining three important facts: first, the cost of the required nursing care of the sick; second, the cost of nursing education, and third, the cost of nursing in relation to medical education.

The first question (the cost of the required nursing care of the sick) can not be answered until studies also now in process as to the care required are completed. For many years we have been content to assign a student nurse to the care of from ten to thirty patients at night without the least attempt to determine what was implied by such an assignment. Our only measurement of the adequacy of the service she rendered was supplied through the fact that in the case of the serious illness of a person of means one, two or even more graduate nurses would be demanded. The study by Miss Sellow, of the Children's Hospital of Western Reserve University, which revealed an average of seven hours as the required nursing care per patient per day, and the time study of a variety of surgical procedures made by Miss Tracy, of the Yale School of Nursing, are but two of many that will be required before this question, fundamental to intelligent care of the sick and *ipso facto* a reasonable cost of nursing service is answered.

It is important to co-operate so far as possible with the general university facilities, not alone because of the economic advisability of such an

arrangement, but because of its educational value. Nevertheless, a school must at all times be assured not only of adequate space, but at such hours as may be desirable from the standpoint of the curriculum, in the case of the school of nursing a peculiarly difficult problem. A separate teaching building is always desirable but not always a necessity. There are, however, certain class rooms or laboratories peculiar to the needs of the school and these must be provided.

It is probable that the dormitory facilities for a school of nursing connected with a university will be increasingly combined with such facilities for other students—undoubtedly a desirable arrangement, but again in the case of a school of nursing the importance of suitable, even attractive, housing facilities can not be over-emphasised, for it must not be forgotten that the curriculum imposes a heavy physical as well as mental strain, and there is, therefore, no branch of education which so justifies the provision of attractive domiciliary facilities in close proximity to the school.

But beyond the provision of class rooms and laboratories or residential facilities is the expense involved through the required clinical experience. I am not using the word hospital, for I wish to imply a much greater variety of experience than the word hospital suggests, and I shall discuss in some detail this subject, for I consider the relationship of the university to the institutions and organisations in which the clinical experience is to be obtained is an exceedingly important matter. Where the clinical experience is obtained through institutions entirely controlled by the university the problem is not great, if it exists, for the faculty of the school of nursing is *ipso facto* charged with the nursing service; but where the connection is through affiliation provision should be ensured for the joint function, educationally in the school of nursing

and administratively in the institution, of the various members of the faculty through shared selection and support.

A programme of practical experience designated as the case assignment method, a method that follows closely the English system and which provides that to the students are assigned one or more patients rather than a series of nursing procedures is, we believe, increasingly recognised as the most effective educational method. This is, however, a time consuming and therefore costly method, for a modern feature of the system is the requirement of case records and studies in every branch of clinical experience and in the preparation of which the student is allowed free access to the medical records. She is further charged to inform herself as fully as possible of all factors, social as well as physical, bearing directly or indirectly upon the case: a method through which alone we believe it possible for her not only to master the required skills but to attain that intelligent and sympathetic understanding of the patient and his mental and physical needs that will awaken an interest extending to a shared responsibility in achieving the best end results. This implies not only a high degree of technical skill and an understanding of the underlying principles of the required procedures, only acquired through a broad and sound professional preparation, but an insight into the social forces and means that bear or should be brought to bear upon any given case. Can she function in so comprehensive a manner is a reasonable question. More frequently both directly and indirectly than would at first appear, but a most important first step is an *awareness* of the part these factors play in the cure and prevention of disease, an awareness of the increasing means for dealing with such problems.

Every student should be ensured within a few days or hours of the



varied clinical experience included in the curriculum, a provision not possible in the hospital schools, depending as they do wholly or mainly upon student service. Furthermore, in this clinical experience, whatever the branch, surgical, medical, pediatric or obstetrics, should be included all possible aspects of any given subject. For example, the course in medical nursing should include a period in the Tuberculosis, Syphilis and Skin Clinics, as well as in the General Medical Clinic of the Out Patient Department, and in the Communicable Disease Department not less than in the general medical wards.

The Yale School of Nursing has recently issued a bulletin which presents a complication of student records and case studies required for the course in Pediatric Nursing. Included in the student's experience in this branch is a period in Medical Pediatrics, the Formula Room, Surgical Pediatrics, Nursing in Communicable Diseases, the Pediatric Clinic of the Out Patient Department, and in the Nursery School: the latter providing a brief but important opportunity of observation and study of the normal child through a most modern programme of child guidance and study.

The various branches in the pediatric course not only indicate the variety of expressions into which any given subject falls today, but present the wider interpretation of her function demanded of the nurse and deeper insight into the problems involved in child care and direction. The value indeed of such insight extends beyond the child to the adult.

The records selected for this publication were mainly submitted by the class of 1929. The student whose conception of the possible application of nursery school principles in the home or in the wards of a hospital appears in the bulletin (a student may I say in passing who at first questioned the value of this experience) stated that she felt it had contributed more than

any other course to her adaptation to the later experience in mental diseases.

It has for many years been our belief that an experience in mental diseases should be included in the basic professional course, and that under right conditions the interest of the most highly qualified women would be turned to that field. It is, therefore, most heartening to find that the field of mental nursing is capturing the imagination of some of our best students, while in others their experience stimulates the interest in child hygiene.

#### *Faculty*

Such a programme as I have suggested obviously demands instructors with a comprehensive general and professional preparation and highly specialised in their particular subject. It entails supervision, bedside instruction and case conferences: again a time consuming and costly programme, but of vital importance to the student and her present and future patients.

Platitudinous as it may sound, we must assert that only is that a good teaching field that demonstrates adequate and skilled nursing care for the patient. Rarely if ever may yet be found the model educational unit that this implies. Such a unit will demand for the usual ward two instructors, functioning as head nurse and assistant head nurse, and one instructor functioning as a ward nurse for every two or three students, and this not less for the stabilisation of the service than for the instruction of the students. The latter will be selected for their interest and sound preparation in the nursing care of that branch of medicine which the ward unit represents. By sound preparation I mean to imply college graduate with a comprehensive professional preparation and additional experience in the specialty selected.

Indeed, I find it not impossible to conceive that a person qualified for the educational or university status

of professor of nursing in pediatrics or obstetrics might function in what is now considered the humble capacity of a floor duty nurse. This conception of the importance of instruction in the bedside care of the patient will, I hope, provide a convincing answer to the oft-repeated question as to whether the students in a university school of nursing obtain any practical experience. To be explicit, in the Yale School, the total number of hours is 5,050; didactic, 698; laboratory, 288; practice, 4,364.

This suggests a second and not less frequent question, often assuming the form of an assertion, to the effect that obviously we would not expect the students with such a broad general and professional preparation would function in the private duty field, but would rather immediately be advanced to teaching and administrative posts, or advanced positions in the public health field. Undoubtedly with the present insufficient supply of nurses qualified for such positions this will be the case. These schools should certainly contribute and widely to the preparation of such instructors and administrators. Further preparation and experience, however, would be required than the basic course, except in the case of students who come with past preparation for and practice in the teaching field or that of social service, and there are many such.

Nor do I believe that under the present conditions of private duty nursing such graduates would feel justified in practising for long in that field; if bedside nursing does appeal to them (and I have just indicated my belief that such might be the case) they would probably prefer an institutional assignment; for in the institution it will be more possible to regulate the hours and to provide those means for educational stimulation and recreation through which alone the vivid interest demanded for continuous effective service in any field is maintained.

### *Publications, Scholarships, Fellowships and Research*

Here we have an almost uncovered field, and one of the greatest importance for its true expression as a university school, for implicit in this is the preparation of specialists, the creation of the literature required, and the research through which alone the term professional school is justified.

Not as yet has any contribution to medical science, so far as I know, been made by a nurse specialising in the bedside care of the sick. It does not, however, require a very great stretch of the imagination, nor is it too aspiring, to conceive that valuable contribution might be made by nurses qualified to co-operate in research in relation to human behaviour.

In the light of research that pronounces every period of human growth, every deviation from the human form as fraught with significance, observation and interpretation, those delicate but essential instruments of science must be finely attuned to be of value, but the privilege of their use is increasingly extended to new groups of workers, and that their findings may have value is acknowledged by recognised authorities.

Once point the way to such function and the field will intrigue and sustain the interest of the best minds. For instance, the problem of juvenile delinquency or emotional instability or immaturity in their relation to the family life suggest opportunity for the co-operation of an agent whose intimate and prolonged association with the family is unique. The child with tantrums, the retarded child, the child with defective posture, is today not less the problem of every nurse than the child with pneumonia. The influence of the nurse qualified or unqualified is greater than is always divined.

An interesting illustration of the opportunity for community relationship is the record of one year's accom-

plishment of a visiting nurse association. An age analysis of the 40,000 closed cases cared for by a staff averaging 175 nurses in one year showed 39 per cent. under five years of age. With the second largest age group from 20-45, 22 per cent. of which was maternity, the average number of contacts with each case was five. Such a staff would cover in five years 200,000 cases or 20,000 more than the entire population of a city the size of New Haven.

The two essentials in achieving our objective are the integration of nursing activities and the integration of nursing education within a given locality, and again integration with the new multiplicity of groups not less concerned with this objective. The best example of an integrated plan of nursing education and community service is probably that of the Western Reserve University, Cleveland, with its five-year combined course, obtained through the university, a chain of hospitals and an unusually well developed and co-ordinated community health programme, and there are numerous other less-developed projects, but giving promise of an eventually well-rounded programme.

### *The Student Body*

As I indicated in my opening paragraphs I did not intend to present a past or present picture of university schools as such, but rather to discuss the profound importance of the furtherance of a programme of education that will commend the profession to that youth of today that by accepted measurements of mental and physical ability give best promise of effectively furthering the profession's ends. Of vastly more importance than the provision of teaching facilities and equipment is the type of mind attracted to the field.

It could, I think, be asserted that one of the significant changes that has taken place in human thought in recent years is the change concerning knowledge. The point of view to

which I refer is most clearly presented, though in different ways, by two present day authorities. The one, Professor Dewey, characterises the former point of view as contemplative knowledge, in contradistinction to practical or applied knowledge.

"There was bequeathed," he said, "to generations of thinkers as an unquestioned axiom the idea that knowledge is intrinsically a mere beholding of viewing of reality—the spectator conception of knowledge. So deeply ingrained was this idea that it prevailed for centuries after the actual progress of science had demonstrated that knowledge is power to transform the world, and centuries after the practice of effective knowledge had adopted the method of experimentation. . . . Our present feeling that associates infinity with boundless power, with capacity for expansion that knows no end, with the delight in a progress that has no external limit, would be incomprehensible were it not that interest has shifted from the esthetic to the practical; from interest in beholding a harmonious and complete scene to interest in transforming an inharmonious one."

Professor Whitehead, of Harvard, likens the present day attitude toward knowledge to a storehouse or a mine:

"The whole change has arisen from the new scientific information. Science, conceived not so much in its principles as in its results, is an obvious storehouse of ideas for utilisation. But, if we are to understand what happened during the century, the analogy of a mine is better than that of a storehouse. Also, it is a great mistake to think that the bare scientific idea is the required invention, so that it has only to be picked up and used. An intense period of imaginative design lies between. One element in the new method is just the discovery of how to set about bringing the gap between the scientific ideas and the ultimate product. It is a process of disciplined attack upon one difficulty after another."

There is obviously no conflict between these conceptions, both emphasise knowledge as a dynamic force and both indicate the importance, if the finest fruits of labour are to be realised, of bringing the best available thought to bear upon the project in hand.

The great psychologist, Thorndike, for instance, asserts that the mind that has but one master is the servile mind—that originality and initiative, these important factors in creative or constructive work, by no means spring from native ability, but have been shown to be responsive and richly responsive to cultivation through association with the past and present thought.

The finest expression of youth to-day demands as did the youth of the past, a life of mental satisfaction; but viewing life through the eyes of science as it was not given the youth of the past to view it, it will not respond to the appeal of the emotions or be satisfied with the merely useful or commercially advantageous, demanding rather a field pregnant with the creative implications of scientific findings. In this it is responsive to the call of the day and hour, for science that has been so generously and effectively busy with man's purposes has embarked on the most challenging quest of the ages—the how and why and whither of man himself.

The place of nursing in this programme needs neither exposition or defense. Of the importance of a sound and diversified programme for the field there should be no argument. Epitomised, the desirable qualifications for a student entering a school of nursing are maturity, culture and ability. It is little short of incredible that today with many thousands availing themselves of the preparation most likely to ensure these qualifications that a college education or its equivalent should not be acknowledged as at least desirable, if not essential, and that less than high school should be accepted as an entrance requirement to schools of nursing.

Nursing stands today on the outer edge of the third cycle of her social function. With hesitation in the past but with full assurance today I assert that in the immediate future the professional content determined as necessary should rest upon an educa-

tional function that ensures without peradventure immediate, intimate and continuous association with those means through which, and through which only, the opportunity of nursing will be justified by her contribution. To again quote from Professor Whitehead:

"The justification for a university is that it preserves the connection between knowledge and the zest of life, by uniting the young and the old in the imaginative consideration of learning. The university imparts information, but it imparts it imaginatively. At least, this is the function which it should perform for society. A university which falls in this respect has no reason for existence. This atmosphere of excitement, arising from imaginative consideration, transforms knowledge. A fact is no longer a bare fact: it is invested with all its possibilities. It is no longer a burden on the memory; it is energising as the poet of our dreams, and as the architect of our purposes."

There could be no more convincing evidence of progressive educational thought in the field of nursing than this increasing alignment with the institutions of higher education, and in this alignment it does not differ from other fields of life activity, to wit, engineering, agriculture, home economics—which began with cookery and has now arrived at mothercraft—a fact important to emphasise, for only through a grasp and an exceedingly comprehensive grasp of social evolution in its educational expression, can we hope to correctly interpret and intelligently direct the path of our profession in the great onward sweep of civilisation.

It is indeed true that there has been and still is "a clash between the present ruling aim of specialisation and those integrating tendencies from which the future has most to gain."

Nursing must be seen as an integral part of an ever changing and expanding mosaic of means for an ever greater objective—an integral part, but not less a complete entity. The nurse, a specialist, expressing her function through many specialties.



each demanding a content imposed upon the content accepted at any given period as basic for that period. The nomenclature alone of any given branch of medicine is suggestive of the variety of divisions into which, whether dealing with the physical or the psychic, the art or science or both of nursing falls.

In discussing the problem of nursing education, Dean Winternitz, of the Yale School of Medicine, has emphasised these facts, finding the answer to the problem in the new relationship:

"The public health problem is not only the problem of infectious disease, metabolism, etc., but it is also the problem of the adjustment of the individual to his environment from a psychic standpoint. This is the most pressing problem that public health, and nursing, and medicine have to face in the future.

"Somewhere there should be an integration to prevent the disassociation which this development creates. There should be somewhere something sufficiently broad, sufficiently impartial, sufficiently free, unhampered by definite association with one or another of these great biological problems and still capable of understanding enough of their detail so that each will be benefited the more by the other's contribution. Such a superior organisation can only be supplied by a great university. This only can afford specific fields the tools necessary to their work by rendering available the results of investigation in pure science.

"The proper association of nursing and medicine can only be attained through university affiliation. If these schools are sufficiently close geographically, and can have contact of personnel through the various university organisations, the best and the happiest conditions may be created."

It is impossible for us ever to hope to visualise even the section of this stupendous drama in which nursing is forced to play its infinitesimal part. To grasp in any measure the import of the tasks is to stand aghast at the limitations of our knowledge. dare to hope, a finer civilisation.

To be brought into daily, hourly contact with defective bodies and dis-

traught minds on the one hand, and on the other to sense but faintly the significance of these human relationships, to glimpse but the findings in the laboratories of study and research, is to press on with renewed courage, enlarged vision, and above all, belief in the creative power of the *collective* mind and will of man.

To interpret the promise of the period upon which nursing has now entered, we would have to reproduce the days not so far in the past when the sick-poor or the victims of pestilence lay in the streets in rags, their sores festering, their plea only for a cup of cold water. Even when later they were relegated to the asylum and the pest house, the condition of the sufferers was not greatly improved. Ills to which man was a prey for centuries have now been tracked to their lair and destroyed, while those that are still evading the eye of science are today housed with safety to all under the same roof, often in the same ward.

Today in truly beautiful surroundings may be found many who in another time might, would probably have, lain manacled and unattended in loathsome cells. Here we see frenzy reduced to serenity, hope restored to the despairing, inconsequence effectively motivated, and this is but the beginning of things that are to be.

We do, indeed, still live in the country of the blind and in the tower of Babel where many tongues are spoken and none are really understood of another, but none can deny the growth of psychic light. Of whatever aspirations, beliefs or conceptions enjoyed by the former generations, the advancement of knowledge may have deprived the present; it has at least set it to work on so great a project that their state in the hereafter, so important to our forefathers, has become a matter of small moment, for consciously or unconsciously this ardent army of youth is laying the foundations for a new, and let us dare to hope, a finer civilisation.

## *The Need for Publicity in Nursing*

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### INTRODUCTION

That the subject of this paper "The Need for Publicity in Nursing" should have been included in the programme of the Congress would seem to imply at least that it is one needing to have the strong light of profession in council (as we might justly consider an International Congress) thrown upon it. Exchanging experiences and bringing the matter to free discussion may enable us, perhaps, to realise more fully the significance of "publicity" with its advantages and possible disadvantages in the development of the profession as a whole. There is a section of our profession which regards our services to the public as the only publicity necessary or desirable, but perhaps further thought in the matter will serve to show us that if we stop at that boundary, we may be failing as a service of national importance to discharge our obligations to the community. It is the aim of this paper, therefore, to raise points for discussion which may enable us to determine a clearer policy in our relationship to the public generally. The term "publicity" is familiar in the realms of industry and commerce where it aptly defines what is now becoming a world campaign in making information known. Its use in the professional field of medicine in my own country, and possibly in others, has perhaps been more closely associated with unprofessional methods, and publicity intentionally employed by an individual member of the medical profession with a view to bringing his name before the community, is regarded as unethical and detrimental to the status of the profession. While our own profession respects this ethical standard, which safeguards in its principle the disinterested nature of true professional service, the word "publicity" remains a good one and for the purpose of this paper will be

interpreted broadly as the act of making non-technical information known. The question before us, therefore, is the need for giving the public further information with reference to the nursing profession.

### PASSIVE AND ACTIVE PUBLICITY

There are both passive and active forms of publicity, the former being imposed upon us from the time we enter our training and render service in these and other institutions; it continues in our work as district, public health or private nurses when we move freely amongst a varying public in the care of the sick or the teaching of health. In this way the standard of our service and our methods of forming human contacts with the sick as individuals, is Publicity in Nursing interpreted in its highest sense. Our responsibilities with regard to it cannot be over-estimated when we realise that it involves the exposure of technical knowledge which would not be revealed in an organised campaign of publicity intended for a wider and more uncertain audience through the medium of newspapers, posters, pamphlets and exhibitions. The need for the highest quality of this passive form of publicity may safely be taken for granted, and its value can only be increased by raising our educational standards, improving our technique in bedside nursing, and realising much more fully, both in our work and in our attitude towards the sick, that we represent the nursing profession to the public. It rests with us to show that there is a difference between the woman who is trained or training as a nurse, and the willing woman who may be called upon to nurse the sick without any training. If the public attitude towards the profession may seem at times unsympathetic it is possibly because someone has made an unfavourable impression upon the public, forgetting their obligations to

the profession as a whole. May it not perhaps be the school that is at fault here rather than the nurse, who so often displays the spirit of her school rather than her own personality which the school has failed to develop? Our attitude, therefore, towards this passive form of publicity can only be imbued with a determination to aim at the highest standard of professional excellence and a constant questioning as to whether such service is meeting the public need and is demonstrating that it is worthy both of understanding and support. Our consideration rests now with the need for increased activity with regard to organised or deliberate publicity, and to determine some basic principles upon which it may be developed.

#### PUBLICITY WITHIN THE PROFESSION

It will doubtless be conceded without opposition that further deliberate publicity within the profession is not only fully justified, but desirable. There can be few here who have not at some time or other appreciated the significance of such channels of publicity as professional journals, official reports, lectures, meetings, expert speakers or social gatherings. These are all powerful factors in developing a more conscious *esprit de corps* and afford opportunities for the pooling of experiences and the spreading of knowledge, which all serves in assisting us to develop our services to the public.

Representatives of Finland and students of nursing history here today will recall the earlier pioneer struggles for nursing reform in that country and the inspiration they received from the late Sister Agnes Karll, of Germany, who, when in Paris in 1907, said, "Only get a nursing paper and all the rest will come." From this inspiration was born "Epione," the Finnish Nursing Journal, which has done and is doing splendid service amongst our colleagues in Finland. There is little doubt that effective organisation of any profession relies almost entirely for its existence upon publicity within that profession and we cannot expect

support from each other unless we employ channels for giving and receiving information.

We have occasion to acknowledge with gratitude the splendid efforts of those who, recognising the value of such publicity within the profession, have sought to utilise it, often at great personal sacrifice and against what at times seemed insuperable odds. Surely we may take it from our pioneers of the past, from the considered thought of today, that for the welfare of our service organised publicity is essential, that without it possibly we should not be assembled here today and professional organisation itself would be where it stood many years ago.

#### PUBLICITY BEYOND THE PROFESSION

Approving the need for further publicity within the profession, we must now consider whether publicity carried beyond the boundary is desirable or necessary. We must always bear in mind that the public understanding of our problems, and knowledge of such progress as we have made within the profession, both with regard to education and conditions of service, lags far behind the actual facts. There are thousands unaware of the registration of nurses as it exists today, and there still prevails complete ignorance of the organised teaching in our schools, together with all that goes to make up the qualifications of a fully-trained nurse. There is an "awareness" that we have passed from the stage of Sarah Gamp and Betsy Prig, our ancestors of eighty years ago, but practically no knowledge as to how or by what steps we have achieved our present worth and status. The rapid developments in education and organisation within our profession have revealed to us more forcibly than ever before the great potentialities of our service, and in our endeavour to materialise these, we are coming up against barriers, to remove which we realise we must have the sympathy and co-operation both of the medical profession and of the

public. We cannot expect a full measure of support unless our cause is understood and approved, and surely therefore it becomes a professional obligation to the community that we should interpret to them, simply and frankly, the services we place at their disposal and ask them to support. There are, for example, certain problems common to all countries represented at this Congress, though they may vary in intensity. The problem may be "How to supply adequate facilities for nursing education," invariably an economic problem, demanding under the prevailing system of most nurses training support from outside ourselves. Are we likely to obtain a full measure of public or state support unless we frankly make known the need for education and its worth to them? Another problem many countries are facing is how to attract the right type of woman into the profession. Are we likely to get an adequate response unless we make known to the educated public the facilities offered in our schools for a sound professional education, the development of university co-operation and post-graduate study and the satisfaction which the work of nursing itself brings to those who undertake it? Who better than we ourselves can make that known? In the field of public health nursing the same obligation is due to the public if we ask it to help us build an adequate service.

Organised publicity in "Health" on both sides of the Atlantic has perhaps made further strides within the last ten years than has been made in any other field of social or commercial activity. This progress has resulted in publicity in public health nursing, which, however, resolves itself into a "passive" form of publicity in nursing, and the development of the "active" form should not be disregarded. There are countries represented here today striving to obtain some form of state recognition. Why should the state grant it unless the protection which state registration affords the public has been made

clear? Those countries which have secured registration would doubtless agree that without making known their cause—i.e. publicity—they could not have hoped to secure it.

#### PRECAUTIONS TO BE OBSERVED

Making information known within the profession is, however, a totally different proposition to making information known to a wide and varying public and here we must realise first and foremost that the responsibility is infinitely greater where it concerns a body of women rendering public service than if it concerned only the prosperity of those who would bring before the community a commercial product such as a new face cream or labour-saving appliance. In one case it is possible to standardise the excellence of the commercial product; in the other the human factor makes such a thing impossible, and the last thing to be desired is that we should in any way dehumanise or commercialise our services. For this reason alone we need to realise that there are many forms of publicity which we as nurses cannot safely employ without misleading the public and doing harm to the profession.

The greatest precaution must be taken in any form of professional publicity to observe the strictest accuracy as to the facts and value of the idea to be presented. It is a good policy never to offer the public more than one can genuinely guarantee, remembering always that the emotional appeal which may seem effective for the moment does not bring lasting results or the enduring response likely to follow an appeal based upon a genuine understanding of facts sincerely stated. In the same way spectacular demonstrations are to be discouraged since there are dangers, not only of encroaching upon the feelings of the sick we stand to protect, but of defeating their own object by directing the attention to the actual spectacle rather than the cause itself, which would have been regarded more immediately if presented with simplicity and directness. If pro-



fessional publicity is to be developed, we must for our own safety as a profession bring to it a live sense of our ethical responsibility combined with ordered thought and expert judgment. This brings us to "Methods of Publicity" outside the profession, where it is found desirable. One is reminded of the courageous piece of organised publicity, undertaken recently by our American colleagues through the Committee on the Grading of Nursing Schools, the report of which has been published under the title of "Nurses, Patients and Pocketbooks" and covers a study of the supply and demand of nursing service in the United States. I stress the word "courageous" because in making and publishing this survey they must have known that while revealing weaknesses not only of the training schools but also of the personnel of the profession, if what was wrong was ever to be put right, making known the facts was to them essential. They were in fact taking the public into their confidence in the hope of obtaining their understanding and support. This frankness I consider illustrates the best and sincerest form of publicity, and without sincerity publicity, given time, is a bad investment and rightly to be deplored instead of encouraged.

#### ORGANISED PUBLICITY

Such publicity as we have achieved today, whether within or without the profession, has in the main been achieved not as the result of carefully developed plans based on considered judgment, but often by a blind imitation hampered by economic conditions and in many instances haphazard and uncertain. For example, in allocating funds for the development of any project, beyond those for essential postage, invariably none are allowed for making known the project, and such publicity which does develop is the result of additional work placed perchance upon the already overburdened shoulders of those appointed to carry out some other definite part of the project's programme.

Whether our aim is the establishment and building up of a training school, a professional organisation or a public health nursing association, or a campaign of any nature which reflects in the least degree upon the public, may we not safely consider that it is an obligation to budget and plan for publicity as seriously as we plan and budget for the project itself.

In the case of building up professional organisations, however, with which all our countries are concerned, the importance of considering publicity as an integral part of the machinery cannot be overstressed. In our endeavour to enlighten a general public we need constantly to remind ourselves of its variety and to realise its absorption in its own affairs rather than its eagerness to concern itself with ours. It has been well said, "We are concerned with public affairs but immersed in our private ones" (Sir George Newman). The task we have before us in any publicity campaign is to change the attitude of the public mind and not only to arrest their interest but persuade them to action. The Advisory Committee appointed to launch any successful campaign should represent, therefore, as far as possible the widest public interests, and since the object of any campaign is to gain the support and sympathy of the public, it is a good rule to employ, wherever possible, machinery which has already gained its confidence. This again illustrates the importance of attaching a publicity department to our own professional organisations. So that if it is an individual school, a small group of nurses or even an isolated member employed on a specialised piece of work she wishes to develop, the considered and varied opinion of experts may be brought to bear on its behalf, before it is projected through the medium advised as most fitting for its success.

If, for example, a newly established school possessing facilities for a sound education given under good conditions, but unable to obtain the right kind of material, appeals to the publicity department of a professional organisa-

tion, the machinery set in motion on that school's behalf would be through the Speaker's Bureau, School Co-operation, Newspaper Publicity, and the channels employed for reaching parents. If a district or visiting nurse in a rural area, anxious to obtain support for the development of her work, refers it to her organisation, the department, after considering the cause and justification for publicity, would be able to help her reach the public through the medium of newspaper activity, to give advice in preparing copy, to supply suitable literature, posters, outlines of demonstrations and speakers for talks to parents on the value of nursing care and the promotion of health. In the pressure of her routine duties the nurse cannot effectually carry at the same time the burden of active publicity, and her attempt to do so might result in more harm than good to the profession. It would be but another illustration of splendid intentions resulting in the publicity which we have already referred to as haphazard and uncertain. There are countless instances of the most pathetic waste of money and time on the part of zealous individuals who have been tempted into undertaking publicity for the profession by themselves, the result being that, as a result of their limited knowledge of developments and actual facts, the public has been misinformed and both it and the profession whose cause it was their

intention to further have been badly let down. There are such infinite dangers surrounding publicity and so much at stake where it concerns a profession responsible for nursing the sick, that though it may safely be conceded that much more is needed in this direction, unless it is organised and safeguarded through professional channels and expert minds, harm may be done which might take many years to repair.

As I feel strongly that one of the most fruitful methods of publicity within the profession is through the medium of discussion, and there must be many present who have had more practical experience in organised publicity than I have, I should be grateful if some points open to debate which I have brought forward in the paper might be put to the meeting for consideration in the following order:—

- (1) Is organised publicity in nursing beyond the profession itself, desirable?
- (2) The justification or otherwise for utilising non-technical information only for the purpose of organised publicity.
- (3) The advisability of individual members of the profession organising a campaign for publicity in nursing.
- (4) Experiences of methods and results in publicity in nursing which might be useful to those present.

## *Rural Nursing*

By **ALEXANDRA M. WACKER,**

State Hygienic Institute of Hungary, Budapest, Hungary

Rural Public Health Nursing in Hungary, owing to a number of reasons, does not include bedside care, although an occasional demonstration of some simple procedure may be given to a responsible member of the family or neighbourhood. Perhaps one of the most important reasons why this type of work does not need special consideration is the fact that we have properly trained and strictly supervised midwives. Therefore, maternity cases, which, as far as I was able to obtain data, count for far the largest percentage in Visiting Nurse Associations, do not need the attention of public health nurses at all. The law provides for "village physicians" and "village midwives," who have to treat people for fixed rates, and those unable to pay free of any charge. Hospitals, including diagnosis, treatment and beds, are available either through the National Sickness Insurance or the National Sickness Fund. The former includes nearly all types of wage-earning people; the latter one is secured by taxation and serves those who do not come under the insurance scheme, yet are unable to meet their expenses. The attitude of the people toward the hospitals is rather friendly, and the placing of the medical faculties with their hospital service of the three Refugee Universities into provincial cities has a very marked beneficial influence upon the attitude of the people of the surrounding country.

Distances are not so great, as even the remotest farmstead is but at a maximum of 15 miles from the village community, though considering some of the country roads, transportation is not always such an easy and pleasant matter as this would suggest.

It is then obvious that there would be very little need for visiting nurses work.

It may also serve as a further explanation of our policy that the work of health education is entirely new and not an added feature to an already well-established scheme of work, as it happens to be in many other places.

The state-wide organisation of rural public health work is started on the health-unit plan. It is done under governmental auspices, the Ministry of Public Welfare with the State Hygienic Institute as executive. The necessary appropriations are made by the State, the county and in some districts by the Rockefeller Foundation. The latter's contribution is on a diminishing scale for demonstration purposes only.

There are at present five such units in operation, the public health nurse working there being a part of the health-unit team. A central office to secure and supervise uniform standards and efficiency for the nurses is under organisation.

The work begins with a "Survey" in which the nurse has her due share. After determining the most outstanding needs of the district, an intensive health propaganda campaign is started to facilitate the acceptance of the new ideas, etc. This part of the work is carried on by the Health Propaganda Centre, which is a governmental agency.

The public health nurse or, better, "Health Sister," as she is called at home, has included in her programme tuberculosis, school health-work with "follow-up", communicable diseases, mental hygiene, nutrition and special diets, minor problems of sanitation, etc., strongly interwoven throughout with a social service programme. She works in the way of home visits, classroom inspections and teaching, group conferences, clinics, meetings, publicity, etc., as the opportunity arises. It is also planned that in every com-

munity where a nurse works home nursing and home hygiene classes should be given as a part of her programme, not only to the younger generation, but to the mothers and grandmothers as well when their interest is aroused.

The nurse's work in our country is of such nature that she must have a good understanding of all the various problems with which her country folks are confronted, and must be familiar with the intricacies of some of the laws, which is a tremendous help to us.

The Infant Welfare care is always simultaneously extended to the particular district by a semi-private organisation, the Stefania Association, which has a state-wide mandate for that part of the work.

Luckily enough, the "Health-Sister" has no trouble with birth registration, since registration of all births has been required by law since 1897, when the State Bureau of Statistics was first established, or with smallpox vaccination, compulsory for every child under one year of age and repeated during school life ever since 1876. She has no worries about ophthalmia neonatorum, the silver-nitrate order being faithfully observed. Yet she does not need to be envied by her American sisters too much, because there are still plenty of troubles and worries left to her, of which not the least is the sympathy-deserving fact that she has no car, and has to cover her many, many miles a day afoot, and what that means only we country nurses know.

## *Rural Nursing*

By NIKICA BOVOLINI, Instructor, School of Nursing, Belgrade, Jugoslavia

The subject of rural nursing always brings my mind back to those isolated districts in Jugoslavia where, a few years ago, there was no one to bring a little light into the darkness and monotony of a life that was full of hard work and anxiety. Some of these districts had neither schools nor churches. The people knew nothing of the value of good books, because they were unable to read. They were equally ignorant of the benefits of living in hygienically-constructed houses. They had no social organisation where they might discuss progress in the home and in the community, and did not know the pleasant relaxation of games. Their own homes had no attractions for them because of bad housekeeping. Human nature demands variety and entertainment. Can it excite wonder if under such conditions the men turn to the only place in the village where they can find change and amusement—the stuffy, ill-lit wineshop, with an atmosphere reeking of alcohol and tobacco-smoke? It is astonishing that human

beings could exist at all in such surroundings.

Ignorance of better living conditions leads to alcoholism and this, together with venereal diseases and other factors, help to produce weak and incapable generations, the economic and moral break-up of families, and finally the physical and intellectual degeneration of nations.

Everyone who appreciates this problem will understand the value to such communities of the notion of public health and of better and more hygienic living conditions—especially in places where human beings and animals herded together under the same roof, where infectious diseases and death, ignorance and slackness, reigned supreme. Teachers, doctors and nurses came, after free Jugoslavia had been formed, to these places as missionaries. Their ceaseless labour has laid firm foundations on which the happiness and prosperity of nations and of humanity in general will rest. The chief materials with which they are building are education and health measures.



A few years ago the members of the first graduating classes of the Public Health Schools were asked where they would prefer to take positions. Jugoslavia had been without one graduate nurse. They could choose capitals, but our young nurses, full of love for their fatherland, decided to go to out-of-the-way villages as the heralds of a new hygienic life. They decided to work among the people who had never heard anything about hygiene or nursing. They began their work with enthusiasm and they were sure of their victory over unhealthy habits and customs.

We were lucky in Jugoslavia to have most capable leaders as chiefs in this field. The people are looking for education and progress, and our doctors are anxious to have a great number of nurses. In such conditions, we took all the opportunities we could.

Our nurses in isolated districts are having health stations. The doctors from Health Centres come for clinical work and supervision, otherwise the nurse in charge has the whole responsibility. The work in these stations is providing clinical service, inoculation, control of contagious diseases and malaria. Every nurse is organising classes for mothers and young women on subjects of proper combination and use of home products, domestic hygiene and proper care of the child and of the sick. She is not doing bedside care, but in case of illness she is teaching someone in the home, demonstrating bed-making, etc. She is supervising the mothers and girls who have attended her demonstrations or regular course in home nursing.

Our nurse is very busy giving instruction and advice to the village men. She leads discussions about the sanitary location and construction of their homes, lavatories and barns, and the evil of improper use of women in

heavy field work, especially women with young children.

Some of the nurses in their enthusiasm to avail themselves of more opportunities of coming in closer contact with people in order to spread their health gospel, gather the village men and women in evening classes. They teach them reading and writing, and afterwards provide them with health literature.

In secondary schools we already see the uniform of the nurse, where she is teaching the students care of the child and of the sick, domestic hygiene, and also contagious diseases and their control. In this way we prepare our young women to be good mothers and wives as well as helpers to the nursing profession.

The farther we go in our work, more and more we are realising that nursing is not only bedside care and strictly health education, but is connected very closely with social work, mental hygiene, etc. We also realise that results of the nurse's work depends not only on her professional nursing, but also to the extent to which she is introduced to all the problems that may arise in the community.

In hospitals and cities the nurse is supervised by doctor or nurse superintendent. She has opportunities of turning to them for advice, but in rural districts, however, she is often left to herself, and has to make her own decisions.

All the above factors are making it necessary to study very seriously what kind of nursing schools we have, whether they are giving to the students the knowledge which will meet the need of the community, and whether the leaders, who are responsible for nursing education are ready to understand that nursing is a science and that nursing schools have to be the centres for research in that field.

## *Rural Nursing as Health Centres*

By MARY K. NELSON, Franklin County Memorial Hospital, Farmington, U.S.A.

The last United States census, taken in 1920, shows a rural population of over 51,000,000, or about 2.8% less than the urban population. In the Survey of October, 15th 1928, we read "More than 80% of the rural population is as yet unprovided with official local health service 'approaching adequacy'."

These limited health facilities of the vast rural districts is one important obstacle to the better distribution of the nation's total population. Surprising facts are revealed when a comparison is made between urban and rural health reports. The magnitude of this nation-wide health problem is evident when we realise how slow the progress has been in the last fifteen years.

The rural hospital is one of the most valuable aids in the solution of this difficult problem; these small hospitals, when adequately staffed and equipped with facilities for prompt and accurate diagnosis and treatment, serve as health insurance provisions for their respective areas.

The type of rural hospital most valuable to this health project brings us to the subject we have for discussion today, the rural hospital as a health centre. First in order of consideration, we will take the rural public hospitals found in the seventeen states where laws providing for such county hospitals have been passed. Such hospitals, supported by taxes and subject to political control, cannot give what the community hospital does give to the people of the area it serves. The reason is obvious, the people assume the hospital responsibility in response to a community need which they understand. This direct relation to the hospital from its beginning, and the following continued support, prepare them to learn more and more of the health value of its service to the community. With this growing knowledge

there is found an increased intelligent use of the hospital and its different services.

The friendliness of the community hospital is no small detail, but rather a very important asset; community persons as patients and their families learn health lessons under impressive surroundings, and the necessary personal contacts greatly add to the value of the future of this work.

A close relation between the hospital and the health programme of the widely-scattered public schools is an important factor for consideration. Just here we might picture those little schools spread over our great country, many of them as yet the only possible centres for health in their localities. We see them, the splendid work of many hundred county and local public health nurses. Those nurses are the persons who would gladly see these schools become sub-stations for a central health service station, a community hospital. They are the persons who can appreciate how such a connection between school and hospital will afford the present children the opportunity of acquiring a very high estimate of the hospital's value to their health and to the health of those about them. Such an attitude of our coming generation would mark an important constructive phase toward the future service of rural community hospitals.

For rural nurses group effort is an inspiration, even if only in the form of regular hospital contacts and conferences. The corrective work for children comes early to the attention of all. The good laboratory and isolation service provides a valuable check on communicable disease. Then the community problem of venereal disease can, like communicable disease, be assumed by the hospital. Its facilities which make possible earlier diagnosis and treatment of cancer and organic diseases, form an increasingly import-

ant part of its service. Efficient care of accidents in this day of travel is another of its health provisions.

Yet leading all the others is the maternity service. The problem of the pregnant mother without medical attention at birth cannot be solved without this hospital service. The present hundreds of rural nurses doing infant welfare work will gladly welcome the establishment of more community hospitals with their facilities for pre-natal, maternity and post-natal services.

In the rural homes the care of the sick and the attention to the convalescent is not only a pressing need but a remarkable teaching opportunity. The hospitals with nurses for home follow-up and bedside work are able to give complete health service to their communities, but the usual way of meeting this need is by close co-operation between county and local public health nurses and the hospital.

One outstanding example of the rural hospital health centre is the Greater Community Hospital in Creston, Iowa. Here, beginning with a five-bed hospital, there was gradually developed such a large health project that the hospital has become a modern medical centre, large numbers of

doctors and nurses get their preparation for future work while serving a very considerable area surrounding the present large hospital.

The part the rural community can do in getting the hospital established is too frequently not adequate, and many such communities need assistance. The Commonwealth Fund has a Division of Rural Hospitals, and the Duke Endowment has a Hospital Section; both were fairly recently created to help with this rural hospital problem.

In closing, I would like to leave with you the words of Dean Goodrich at the Hospital Association meeting several years ago. She had summarised the community needs of the different services in the hospital, and concluded by saying, "All these things demand, that the hospital of strategic importance in health problems, function either as a health centre within a given area, or at least as a definite link in the chain of health activities required for a community health project".

For me she has clearly visualised the rural hospital in the first sentence, which I will repeat: "All these things demand that the hospital of strategic importance in health problems function as a health centre within a given area".

## *Rural Nursing from the Viewpoint of the Public Health Nurse*

By **ELIZABETH L. SMELLIE,**

Chief Superintendent, Victorian Order of Nurses for Canada

"Rural Nursing from the Viewpoint of the Public Health Nurse" was presented by Miss Elizabeth Smellie, who first described briefly the official health organisation in Canada under which "the health unit plan is rapidly growing in favour and will undoubtedly mean the extension of educational and preventive work to areas at present barely touched. One essential to insure success in the development of this plan appears to be the securing of exceptionally well-qualified personnel."

Two national voluntary organisations figure largely in health work in Canada: the Canadian Red Cross Society and the Victorian Order of Nurses for Canada. (*Editorial Note.*)

Miss Smellie said:

"The strength of the rural as of the urban voluntary organisation, or its weakness, if not well organised and nurtured, is the local administration. Therefore, the greatest possible care needs to be taken in organising to secure a representative and active committee; men and women, repre-

sentatives of official groups, various church bodies and of different racial groups resident in the community, with, and this is most essential, a capable, public-spirited leader. Without wise guidance the best nurse is powerless to work as effectively as she otherwise might, and she will eventually become discouraged. She on her part needs tactfully but persistently to keep alive and stimulate the interest and to familiarise her committee with her work and its problems, so that this community enterprise is recognised as a joint undertaking. If she has a wide-awake Board, the nurse not sufficiently alive to her responsibilities is apt to prove a disappointment and a misfit. To hold together and maintain the interest of a committee in a wide-spread rural area where, during the greater part of the year people are extremely busy during daylight hours, and at other times of year frequently inaccessible, is no easy task. The visits of the supervisor mean a great deal to these scattered groups and nurses, provided she is an understanding woman and aims to time her visits to fit in with local conditions.

#### SOME OF THE PROBLEMS OF A RURAL ORGANISATION

"1. Including too large an area in the beginning.

"2. Launching work before sufficient ground work has been done.

"3. Securing additional local aid later on, unless in the beginning every effort has been made to canvass and organise the local group and to stimulate them to utilise every possible local means of securing financial assistance before outside help is guaranteed.

"4. Limiting the work to one section of a municipality or township with the expectation of receiving a grant from a township council representing all sections, some of which are included in the plan.

"5. The difficulty of developing a county spirit when one section, more populated, better organised, and more prosperous, is anxious to develop its local plan rather than to consider the health needs of the county as a whole.

"6. Inability to cover the ground in bad weather—possibly several months of the year.

"7. The absolute impossibility of providing adequate nursing care and of deciding which service is most essential when educational work is being neglected and the requirements are quite definitely not being met.

"8. The finding of suitable living quarters for the nurse.

"9. Arrangements of such headquarters in a sufficiently central spot to give each section fair proportion of service.

"10. To judge properly how long financial help should be given and how gradually withdrawn.

"11. The problem as to the administrative group—whether it shall be the municipal or township council with a representative advisory group, a central voluntary organisation representing three or four municipalities included in the area with either a small number of representatives from each section or a combination of small auxiliaries in each area, these in turn having one representative in the larger association, to attend central meetings to present their viewpoint.

"12. The difficulty of securing representative and regular attendance at meetings because of inaccessibility.

"The type of committee and its organisation must be sensed after local contact and careful survey of the general situation. It is better that no rigid plan of procedure be adopted.

#### TEACHING

"Undoubtedly more ground can be covered and more contacts made by nurses doing purely educational and demonstration work. Moreover, if these nurses are provincial representatives they come into the community with prestige because of that, and are well received. In the beginning at least their services cost the community nothing, and in general the women in outlying districts are eager to benefit from their instruction. Such work is carried on under the direction of the district or local officer of health and with the co-operation of the physicians resident in the com-



munity. The personal contacts of the provincial nurses, from the educational viewpoint, blaze the trail and demonstrate the need just as demonstrations and travelling clinics held in different areas by the Provincial Departments tend to stimulate and develop general interest in public health work, the human as well as the economic value of preventive work being emphasised.

"Bedside nursing would not appear to be the ideal pioneer service to-day, with the exception of certain areas where its need is especially indicated and in which possibly progress through other methods has been slow because of lack of appreciation or understanding on the part of the people concerned. There are also smaller places in which there seems little prospect of growth of population or of the people being able to finance the work themselves for many years to come, but where the requirements are sufficiently limited so that one feels the nurse doing generalised work, including bedside nursing, might prove to be the more satisfactory type of public health worker to meet the local situation.

"The development of the health-unit plan may quite reasonably be expected to lead to the establishment as time goes on of a visiting nursing service in one or more sections of the unit area, and there would seem to be no reason why such nurses could not work in closest co-operation with the county unit group. From the beginning a bedside nursing service stimulates a community to contribute individually for service rendered. There is a tendency to take for granted that any service provided by a government or in which a government shares, should be voluntary and it is very difficult to overcome this feeling once it is firmly entrenched. As stated before, bad roads and the question of transportation present difficulties in many places. Nurses in some of our Western districts, unable to use their cars, travel to outside points during the months when they are unable to use their cars, by rail, horse and sleigh, snow-mobile or dog team. In one district a plan was adopted during the

winter whereby the nurse moved from one small village to another, remaining in each a month. The women were particularly keen to have home nursing and first aid classes, and in this way it was possible to give them more concentrated and definite instruction. Those in the immediate area requiring nursing attention sent for and conveyed the nurse to her case.

"One would feel that it is necessary for us to make up our minds in Canada that with our broad extent of territory, the differences racially, geographically, and from the point of view of accessibility, that no one orthodox plan can be laid down and universally accepted as the ideal type of health organisation for every part of each province.

#### BEDSIDE NURSING

"In an article in the *Nation's Health* in 1927, Miss Gamble said, 'It would seem to me that to give a fully rounded public health nursing service, bedside nursing should take a definite part of any educational programme. What better way have we to teach than by demonstration? However, with a large field, a limited staff, and a heavy programme we must realise the practical limitations of any nursing service and endeavour to maintain well-balanced public health teaching, which, to the extent it is humanly possible, should include bedside nursing.' This idea seems increasingly to prevail, and from the types of request that come to us, the better organised, from a health and social point of view, the community is, and the more active these forces, the more speedily the realisation comes of the need of an efficiently organised, well-supervised bedside nursing service. More hospital beds are needed, but even more urgently, one would say, doctors and nurses for isolated areas. This means larger government appropriations for health purposes to pay adequate salaries, to ensure professional attention for people requiring it but possibly unable to pay for it, or beyond the reach of it. Our Provincial Departments of Health need to continue to study the requirements of the different communities and to

assist them insofar as they are able, not failing to recognise the value of the voluntary organisation as an auxiliary force, and to recommend appropriations in proportion to the work accomplished. The official Departments of Health need the interest and moral support in their efforts of the public-spirited men and women throughout the country who are leaders in voluntary services. For instance, many of the larger centres are extremely local and there is little eagerness to extend the work outside their own limits. County councils are rather loath to accept additional financial responsibility, but with patience they can eventually be won over. Until such time as county or municipal hospitals are available, out-post assistance will be needed, just as for many years to come, it would appear that bedside nursing service in the homes must be provided, and that it would need to be carried on under voluntary direction.

"Living arrangements constitute a great problem for nurses in smaller and more rural areas, just as in the case of school teachers. The necessity for a sufficient and graded salary must be

recognised. Regular supervision, opportunity provided for attending an occasional refresher course, of a short time off in midwinter or early spring in addition to the regular holiday, of extending help of every possible kind in the educational way, are essential to the well-being of the nurse working alone under adverse conditions or in an isolated spot, in order that she may carry on her work effectively.

"Were there a sufficient number of professionally well-qualified nurses to meet the demands of the rural as well as of the urban nursing field, a most urgent necessity in different sections of the country would still be a well-planned and professionally-equipped training centre to provide field experience in rural nursing.

"To secure the better distribution of physicians and nurses available is a problem requiring the combined wisdom and co-operation of provincial governments, health departments, schools of medicine, medical and nursing associations, directors of training schools for nurses, and the leaders in public life. No one group can handle it alone."

## *The Preparation of a Curriculum*

By E. STANLEY RYERSON, M.D., C.M.,

Secretary of the Faculty of Medicine, University of Toronto, Canada

Women possess a native ability to care for others. The problem in the construction of a training course for nurses is to advise a scheme of personal, practical and educational experiences to which a selected group of women, who are deemed to possess this native ability in a special measure, should be subjected so that they will be able to care more efficiently for others in a state of sickness. The selection of applicants is made on the basis of their suitability, as judged by their personality, their character, their health and physique, and their previous general education.

The provision of personal experiences is necessary for the development of characteristics that contribute to the enrichment of this aspect of the prospective nurse, in order that she may become a finer woman, as well as a trained nurse. Practical experiences are provided by the daily work in caring for patients in the wards of a hospital. Educational or academic experiences are supplied by lectures, demonstrations, classes and clinics. The preparation of a curriculum is dependent upon the relative values apportioned to each of these three aspects and the attainment of a well-balanced result. Should the personal side be neglected, the resulting product will lack that personal and human touch, which is so essential in the care of the sick: should it be over-emphasised, then the technical nursing of the patient is apt to suffer from being too casual. If the practical nursing constitutes the entire training, the nurse so prepared will tend firstly to magnify the mechanical procedures of nursing so that the human side is inadequate; and secondly, to receive insufficient fundamental knowledge of diseases with their causes, symptoms and signs. If the educational and academic instruction becomes the predominant feature of the course in the

first place, both the personal and practical features suffer in consequence of being made subsidiary with the result that the nurse is incompetent to perform her necessary functions: in the second, by gaining too great a scientific knowledge of diseases, the nurse has a tendency to become too professional in her attitude to the detriment of her services in a nursing capacity.

Only in recent years have attempts been made by authorities to study curriculum construction as an educational problem. Most curricula have evolved from past experience and imitation. The basic principles are not agreed upon by educationists, one of the greatest barriers to progress being the prestige given to tradition. The construction of a curriculum on the basis of an analysis of the objective to which it is desirable to attain, is gaining more and more in favour. Even after the aim or objective of a course is decided upon, the difficulty in deriving a course logically from this is of no mean proportions, because of the fact that the statement of the objective is in terms of "ideals" or standards of conduct, as determined by the governing body or individual teachers, whereas the details of the course are drawn up in terms of "activities" or procedures which have to be carried out from day to day. The bridging of this gap may be attempted in various ways: one consisting of listing the activities and then determining the ideals to which these are related; e.g., such activities of the nurse as taking temperature, pulse and respiration, train a nurse in the ideals of accuracy, of observation, skill, thoroughness; another, in the converse by listing the ideals and co-relating the activities. Nursing administrators deserve commendation for the thoroughness with which they have analysed the details of the

activities of the nurse for the purpose of constructing a Training Course. In doing this, there has been possibly a little too great a tendency to over-emphasise the physical activities in contrast with the personal and mental ones, which are just as essential in an efficient nurse. The acceptance of the principle in education of "learning by doing" has greatly influenced modern educational methods. The provision of experience for educational purposes instead of trying to fill the memory with facts, is becoming more and more widely accepted.

This newer method in education tries to supply a training of the ability to think and judge with actual life situations, i.e., in the use of ideas in the control of practical situations. One of the greatest difficulties in constructing courses of instruction results from teachers in many branches of education, including those in nursing, medicine, etc., failing to recognise and accept the maxim that experience teaches. Many women became efficient nurses in hospitals where no academic instruction was given, because they succeeded in learning by experience. Courses have been improved by the addition of didactic and laboratory instruction, but care must be taken that the amount and character of this type of teaching does not interfere with the training and education the nurse receives from her own experience in the wards. Actually nursing patients gives a nurse enjoyment and satisfaction and creates in her a spirit of interest and enthusiasm, an asset in a training course that should be jealously preserved. Too much system and routine or an excessive amount of teaching may dampen an interest that should supply the healthy motive throughout the course.

The accepted principle that educational experiences should take place under conditions that are as close to normal as possible, can be applied in the training of nurses to a greater extent than in most other fields of education. Artificial arrangements, such as the manikin, etc., are unnecessary and should be used as sub-

stitutes for living patients only under exceptional circumstances.

Authorities of modern educational methods are satisfied that the general faculties of memory, reasoning, observation, etc., are not capable of development by practice on one kind of material or subject so that they can be employed afterwards in quite another type of material or subject. For example, a nurse's memory of symptoms of which a patient has complained in the last 24 hours, is not made a better memory because she has had to memorise the doses of certain drugs in *Materia Medica*; her ability to reason logically the explanation for a pain from which the patient is suffering is not improved by practice in calculating the proportions of a diet for a diabetic patient.

Under the older views of education the giving of information was assumed to have an influence on the conduct of a student. The newer idea is gaining ground that the function of instruction is not fulfilled until the information given has modified the conduct of the student. This principle has to be borne in mind when consideration is being given to the particular subjects that are to be selected for instruction, so that each subject and its parts will be placed on the curriculum because of the fact that its presence will have some definite influence on the conduct of the nurse who is receiving it. A study of the manner in which each subject is used should be made with this object in view. For example, instruction in diseases as given to nurses should not consist of a discussion of the etiology, pathology, symptomatology, diagnosis, prognosis and treatment such as is given to medical students, but of the prominent symptoms and signs and the explanation for their presence. A further description of this will be given later.

The efficient bedside care of the sick patient is the main aim of the nursing course. The many nursing procedures and physical activities and the academic instruction supplied in lectures and demonstration classes are means to this end. In order to attain

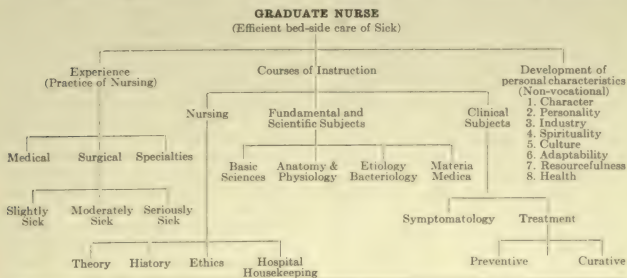


this chief objective a realisation that the patient is the focal point of the course requires emphatic endorsement on account of the growing tendency to overshadow it by courses of instruction and the technique of nursing procedures.

The following schematic outline of

practical experience requires careful watching for fear that the course becomes largely an academic one with the practical nursing as a subsidiary part.

The present practice of grading the practical work of the nurses in the hospital on the basis of particular



Nursing Education is presented for consideration and analysis. Three main divisions are suggested, viz.:

#### I. EXPERIENCE;

#### II. COURSES OF INSTRUCTION;

#### III. DEVELOPMENT OF PERSONAL CHARACTERISTICS.

The practical training which the nurse undertakes in the medical, surgical, obstetrical or other wards of the hospital, provides an ideal opportunity for her to acquire the necessary experience to become efficient. The basis of this aspect of her training lies in the fact that it is with patients. She assumes the responsibility for the care of a human being; she performs the necessary acts to assist him or her back to health, and by so doing gains a particular experience, a repetition of which, with many types of patient, enables her to become more and more proficient. Practical work with patients forms the back-bone and body of the nursing course, to which academic instruction and personal development supply the finish and humanity. The inclination in recent years to substitute more and more instruction by lectures and demonstrations for

nursing procedures, such as the making of beds, the taking of temperature, pulse and respiration, the changing of surgical dressings, etc., makes the nurse responsible for the efficient performance of certain mechanical procedures upon a number of patients, in consequence of which the responsibility for the patient is minimised and made subsidiary to the nursing technique. The repetition of the work by this system from day to day throws the care of each patient more and more into the background and makes nursing an impersonal affair, so that the nurse thinks more of the neatness with which she has made the bed than whether the patient in the bed is made comfortable or not. This system of grading the nurse's work by procedure is an attempt to imitate the principle of standardisation in the manufacture of motor cars (e.g., Ford), in which each step in the production of a car is carried out by successive groups of workers until the car is completed. The application of this principle to nursing of patients reduces nursing to the level of an impersonal, mechanical form of procedure, and detracts from its intimate personal nature.

The basis of the grading of a nurse's practical work on patients should be made upon the degree of mildness or seriousness of the illness from which he or she is suffering. Probationers might be assigned to convalescent or chronic patients who need little more than ordinary personal care, such as washing, bed-making, etc., the junior class of nurses with this experience are then detailed to moderately sick patients upon whom they are required to make observations of their signs and symptoms, to record objective findings and to administer simple types of treatment; and the senior class, who have gained experience of cases of many kinds and have shown their capabilities are sufficiently equipped to nurse cases in the most precarious stages of disease. The devotion of her entire attention to a single serious case should complete the practical aspect of the training. Responsibility for the care of the patient should form the key-note of her experience in the hospital wards.

In some curricula, practical nursing would appear to be synonymous with technique in general nursing procedures. In the outline of a course on elementary nursing fifteen lectures are suggested on such subjects as dusting, care of patients' clothes, care of rubber goods, care of the dead, etc., while only six are concerned with bed-making, bathing, care of mouth, prevention of bed-sores, which are of use in the care of the sick patient. In fact, no heading indicates that instruction is given at all on how to make a patient comfortable or to assist him to regain his health, or nursing per se. Technique is the dominant feature, and the patient a mere incident upon whom the procedure is to be performed. A similar tendency is apparent in the lecture courses on Medical, Surgical, Obstetrical nursing, etc., in which the minutest details of technique are described, but the patient scarcely seems to be sufficiently important to be worthy of discussion. The object of the course in Charting is "to teach the nurse the importance of accurate records from the viewpoint of science

and law". The fact that accurate records might have some value in determining the progress of the patient and in influencing the treatment that might be instituted for him, again is thrown into the background.

## II. COURSES OF INSTRUCTION.

### A. THEORY OF NURSING

Concurrently with the practical work, instruction should be given by a limited number of lectures dealing with the broad principles of the care of the patient. The object of such lectures should be that of helping the nurse to perform her duties more intelligently, and consequently more efficiently, and not of presenting the details of the technique of medical, surgical or other procedures, which can be learned better by "doing" than by listening to a lecture on them. Most lectures of this type should be inspirational, rather than to impart knowledge.

### R. FUNDAMENTAL AND SCIENTIFIC SUBJECTS

1. Chemistry, Physics, Biology.—One or two lectures on each of these subjects should be sufficient to give the nurse some conception of their basic principles and the relationship they bear to the chemical, physical and biological processes that go on in the human body during health and their disturbances during disease. These should be rather of the popular nature and not with the intention of creating a scientific point of view or making the nurse feel that a knowledge of these is required in order to make her work scientific.

2. Anatomy and Physiology.—The nurse's knowledge of these subjects should be sufficient to enable her to perform her duties efficiently.

Just how much this consists of has not yet been definitely determined. A careful study should be made of the various ways in which a nurse uses her knowledge of the structure of the body and the functions of its organs and systems in order that a course of instruction may be defined which will fulfil logically the purpose for which it is intended. No attempt should be

made to give more than a broad conception of the most important anatomical structures and of the manner in which the organs and systems function in a healthy living person.

3. Causes of Disease.—The nurse should be given a general idea of the ways in which disease and sickness are caused and the effects that such causes have on the structure and functions of the body in the production of signs and symptoms. The relationship of age, sex, environment and occupation, injury, bacteria, etc., to the occurrence of disease should be discussed in general terms. Endeavours to teach the nurse the morphology of organisms, their culture and identification are not warranted. The changes in the structure and alterations in their functions of the organs and systems of the body should be described in a broad and comprehensive manner without delving into their details.

The mechanism by which the common symptoms and signs of disease are caused by altering the structure of the part might be explained, e.g., the redness that occurs during an inflammatory reaction, the swelling from this or from tumor formation or from failure of the normal heart action. And similarly, the production of symptoms that takes place in consequence of the disordered function of an organ or canal such as a diseased lung or obstructed intestine.

4. Materia Medica.—The relegation of this subject to a comparatively unimportant position in the course for doctors by medical educators and replacing it by Pharmacology and Therapeutics has not been taken cognisance of in the construction of Nursing Curricula. Much attention is given to instruction on drugs that are but rarely prescribed by the physician, so a selection of the few important drugs that are commonly used at the present day is an essential step towards a revision of this course. Observation of the action of drugs used on the patients in hospital is of far more instructive value than lectures of a theoretical character.

#### C. CLINICAL SUBJECTS

**SYMPTOMATOLOGY.**—This heading is chosen instead of Medical Diseases, Surgical Diseases and their various subdivisions because lecture courses of this kind that are drawn up with the object of systematically covering the various diseases are largely valueless for the nurse.

Medical educators are recognising the futility of academic systematic courses of lectures regardless of their practical application and substituting practical clinical work on patients in their place. Nursing educators might take heed of this action and realise that nurses gain their most valuable knowledge of diseases by their practical nursing of patients suffering from them. Just as the attempt to give instruction in each disease to every medical student has been replaced in the medical course by instruction in their principles and the ways in which these are applied in certain type cases, so instructors of nurses should teach the main aspects of the commoner diseases by clinical classes in the hospital wards and by clinical lectures on patients, illustrating the subject under discussion. "No lecture on disease without a patient" is an ideal difficult of attainment, but the underlying principle involved should be borne in mind in arranging courses for nurses on diseases.

This might be effectively carried out by (a) Clinical lectures; (b) Clinics or Ward Rounds.

(a) Clinical Lectures.—Instead of giving a course of didactic lectures on Diseases of Digestive System, under such headings as stomatitis, gastritis, gastric ulcer, carcinoma, diseases of liver, describing the etiology, pathology, bacteriology, symptoms and signs, diagnosis, prognosis and treatment of each of them, patients should be used to illustrate their main signs and symptoms, such as a pain and redness of mouth and tongue, vomiting, pain in abdomen, distension of abdomen, jaundice, etc.; instead of lectures on Respiratory System, e.g., bronchitis, bronchiectasis, asthma, pneumonia, pleurisy, patients illustra

ing cough, expectoration, pain on respiration, rate of respiration, cyanosis; instead of lectures on abscess, ulceration, gangrene, cases showing redness, swelling, sloughing surface, dead tissue, wound discharges.

(b) Ward Rounds.—So that a nurse may see and observe for herself as many conditions as possible, ward rounds with one of the medical staff or the nurse in charge of the ward supply a most valuable method of instruction, which is not used to anything like the extent to which it might be. By this method, the nurse becomes familiar with the changes in symptoms and signs over a period of days or weeks and realises that disease is not a fixed entity but an evolving process that grows better or worse from day to day. She familiarises herself with symptoms and signs as they occur in patients and does not have to listen to theoretical lectures or to memorise text-book notes that are difficult to apply to patients.

**PREVENTION OF DISEASE.**—The recognition that prevention of disease is better than cure is one of the outstanding advances that is causing a revision of the curricula in medical schools, as well as a change in the character of practice of the general practitioner. Its recognition in the education of nurses deserves thought and consideration.

The nurse should know how to keep herself in a healthy condition so she will not fall a victim to disease and be unable to continue the performance of her nursing duties. The nurse also should be prepared to direct patients in the principles of health preservation and disease prevention. Most of the principles of Public Health are valuable only for those nurses who specialise in this particular field, and instruction in them should be undertaken as post-graduate work.

**TREATMENT.**—On admission to hospital, patients are sent to certain wards, in accordance with a tentative diagnosis of a disease for which treatment of a medical, surgical or other nature is indicated. To a large extent such a subdivision of patients is the result of hospital organisation, and is the convenience of the attending

staff of physicians. Every person that enters a hospital for treatment is primarily a patient. The personal care in its broad sense that this patient receives is the same whether he is on a medical, surgical or other ward.

In the instruction on these general methods of treatment, the attention of the nurse should be focussed on the patient who is receiving the treatment instead of on whether the treatment is medical, surgical or otherwise, or whether the nursing is medical nursing or surgical nursing or special nursing. The introduction of such a course into the Nursing Curriculum has sound pedagogical principles to support it, as well as the advantage of economy of time.

Doubtless, certain cases require treatment that is used only on the medical wards; others, treatment that is given only on the surgical ones, and so on, but these specialised types of treatment can be learned most advantageously at the time when the nurse is on duty in the wards where such cases are.

### III. DEVELOPMENT OF PERSONAL CHARACTER.

The extra-curricular development of the nurse during the period she is in training is deserving of careful thought and consideration. At this time she is not only learning to be a nurse, but also is maturing as an individual member of society. A recent survey made by the Commission on Medical Education gave the replies of a large number of doctors with reasons for their success in practice. The reason most commonly given was character, followed by personality and industry. It was interesting to find that knowledge ranked about fourth or fifth, indicating that individuality counts as much or more for success as the knowledge one happens to possess. The inherent qualities that a nurse has as the result of her birth, upbringing and school education, develop still further during her course of training. Opportunities should be provided for this development to take place by supplying facilities for reading the literature of the day, for taking part in sports and for the enrichment of her life in its moral and spiritual aspects.



## *Trends and Development in Vocational Education*

By W. W. CHARTERS, A.B., LL.B., B.Pd., Ph.M., Ph.D.,  
Professor of Education, University of Chicago, United States

Trends in vocational education in the United States radiate from the Smith-Hughes Act of February 23, 1917, as the empowering legislation which created the Federal Bureau of Vocational Education. Prior to that date, vocational education exhibited no trends other than those that had been in evidence for decades. Manual arts had been introduced earlier but had been vocational only in theory; private industry used the usual trial and error methods; and some apprenticeship activities were in evidence in the trades, particularly in those which were unionised.

With the establishment of the Federal Bureau in July, 1917, a new era of education for and in the vocations was inaugurated. By the Smith-Hughes Act vocational education achieved educational status and certain well-defined trends are now apparent at the end of a quarter century.

One characteristic of vocational education is the increasing use of job analysis as the basis for curricula. It is now the customary procedure in scores of vocations to make a careful analysis of the activities, operations, duties, problems, or difficulties of a vocation. The results of these analyses provide specifications for the curriculum. The learner is to be taught how to perform the listed activities. These become the topic of the curriculum; the methods of performing the activities are the content of the curriculum. Thus the curricula in agriculture constitute a constellation of courses whose objectives are to prepare students to be dairy farmers, poultry raisers, and the like, and whose content is specified by an analysis of the duties, activities, or problems of the dairy farmer, the poultry raiser, and so forth.

When time permits the opportunity may be seized to broaden the course of instruction beyond the mere learning

of operations of the trade to the conclusion of auxiliary and fundamental information which explains the reasons why the vocationalist uses the techniques he does. The machinist is taught the underlying mathematics, science, English, or art that he needs in order to understand the operations which he performs, and to use them intelligently. The status of the craftsman is thereby raised from that of a mere routine mechanic to the position of an intelligent tradesman.

Thus the trend in the curriculum is toward a logically organised body of materials which is selected upon the basis of activities of the vocation. That this trend is not conspicuous in every vocation does not alter the fact that it is a persistent trend which is accepted in theory by vocational theorists, and is increasing rapidly in range of application.

In vocational instruction the most conspicuous trends have developed from the project concept. The essential nature of the project consists of the idea of learning in a natural setting.

The application of this technique of instruction has resulted in the development of two trends: In the first place vocational education is emphasising practical skill as opposed to theory on the one hand and amateurishness on the other hand. The youth who operates a machine during his learning process is graduated from school with a degree of practical skill which enables him to carry on at once with his vocation. It is obvious, of course, that in the apprentice type of vocational training this practical skill has always been secured but in school training for the vocations the idea was new in its inception. In school students learned only from books prior to the Smith-Hughes enactments.

The project idea, in the second place, establishes a new trend in the selection and presentation of subject-matter. From this practical point of view, subject-matter is selected and used as needed. For instance, the machinist is taught only the mathematics necessary for the operation of his machine; he is not given a general course in mathematics. The youthful farmer learns those facts about physics which are of use in running farm machinery and performing other farm operations. The home maker is taught those facts about chemistry which will make her intelligent in the preparation of foods, in maintaining sanitary conditions in the home, and the like.

Another trend observable in vocational education within the schools is the inclusion of a generous amount of so-called cultural subject-matter in the curriculum. In the Smith-Hughes courses in the high-schools half the time only is spent upon strictly vocational courses; the other half is given to cultural courses. These are included because in American education the conviction is substantial that the worker is first a man and second a craftsman. He has many important duties and interests which are not included in the vocation, and for these it is felt that training should be given. Particularly serious is this consideration in view of the fact that the working day is being so shortened as to provide hours of leisure which should be filled by worth-while activities and interests. Millions of men and women have time on their hands which, it is felt, they do not know how to use in a profitable manner.

When we turn from the field of vocational education in the schools where job analysis, project techniques of instruction, and the introduction of cultural material into the curriculum are conspicuous tendencies, we may consider the field of vocational education in the industries. Here we find complementary tendencies at work. That is to say, while vocational education in the schools is seeking to embrace practical skill as an out-

come, vocational education in the industries which normally provide skill is seeking to incorporate theory or school learning into its curricula. Private vocational education is learning from the Smith-Hughes schools.

Courses of instruction have been introduced into many private organisations. Not so long since, salespeople in department stores were hired and immediately placed behind the counter. Today salespeople are ordinarily assigned to classes for two days or more before beginning to sell, and later during their employment they are given extended courses in salesmanship, colour and line, arithmetic and the like. In numerous large institutions prospective executives who seem to display administrative talent are taken off productive jobs and placed in executive-training courses.

More significant than course instruction, though not so well developed, is what is known as training on the job. This term denotes the techniques used for foremen, supervisors, executives, and the like in giving individual attention to subordinates. Obviously, course instruction is useful as a supplement to experience; it is not a substitute. Any art is learned only by practice of the art.

The call for supervision and training grows more insistent as industry speeds up and production costs are calculated to two and three decimals. The executive must, as a matter of necessity, see that the most effective methods of production are used by all his men.

In the private organisations, however, little attention is paid to the cultural elements of education. Here and there non-vocational courses are given. But ordinarily business organisations are concerned only with vocational training. They are quite willing to use company time for the giving and taking of vocational courses but they leave liberalising courses to the interests of employees outside of business hours.

So interested has business become in training that in several centres and in many organisations research departments are maintained to perfect better methods of instruction. A number of commercial organisations find the providing of training materials and technique for business clients to be both useful and lucrative.

Thus we see that business organisations show tendencies toward the increasing use of class instruction, individual instruction on the job and to research in methods of training.

When we turn to liberal or cultural education, we seem to discern indications of influence by the vocations. On the one hand, techniques developed in vocational education have been borrowed by the schools to use in non-vocational courses. For example the techniques of job analysis are used in selecting words in spelling, rules in grammar, and cue-concepts in the social sciences. The project idea has been adopted bodily by the elementary schools from the vocations. On the other hand, vocational objectives are finding increasing importance in the elementary school curricula.

It is doubtful, however, that the vocational objectives will ever dominate the curriculum of the public schools. The elementary schools show no tendency to desert their task of providing a mastery of the fundamental tools of civilisation and the high schools are still the people's colleges. Indeed, the vocational-education enthusiasts are mournful in contemplation of the small growth of the vocational idea and the dominance of extra-vocational and college objectives, within the vocational curricula of the school. The thoughtful spectator, however, sees that vocational education is influencing cultural education (as it should) but he does not fear the dominance of culture by vocations. The vocational influence can proceed far beyond its present

position before even a proper balance between culture and industry has been secured. Elementary and high-school courses of study have been too strongly academic in outlook and too slightly functional in point of view.

A description of the trends in vocational education will not be complete without reference to the professions. Schools for the training of doctors, lawyers, and so forth have been in operation for decades and centuries. Ordinarily they have been dominated by academic conditions and ideas, but recently some of the technique described above has been applied to the professions. Specifically, job analysis has been used to revamp the curricula of colleges of pharmacy, library schools, and teachers' colleges. This procedure has led to the inclusion of much useful new material and the elimination of traditional materials which are no longer useful—if they were ever of value in professional training.

In conclusion, reference should be made to the status of nursing education. We have hundreds of schools for nurses. Practically every hospital conducts such a school—frequently to provide cheap hospital service. Job analysis has not been used to determine the curriculum. Training ordinarily is of the apprentice type with minor emphasis upon class-room instruction. Cultural courses are seldom provided. Training on the job is a basic technique of instruction. Numerous examples of substantial training courses can be cited; but on the whole, nursing education has not yet felt to a marked degree the influence, trends, and tendencies described. The most hopeful activity that has appeared on the horizon of nursing education is the committee on the grading of nursing schools which gives promise of initiating vigorous and wide-spread forward-looking activities.

## *The Community Need in Relation to the Education of the Nurse*

By M<sup>LE</sup>. CHAPTAL,

President, The National Association of Trained Nurses of France

For the purpose of clarity this brief survey is divided into two parts:

### 1. The Community Needs:

(a) Cure: The nursing of all types of curable diseases—mental and physical, in institutions and private homes.

(b) Prevention of disease and improvement of public health: maternity and child welfare; fight against social ills; social service.

In theory any community may have to meet all these demands at once; but in practice a given country only realises the necessity to meet each need as progress is made in hygiene, in preventive work, in methods of treatment and cure or in the development of relief work and social service.

How does the present education of the nurse meet this need:

The present-day training given to the nurse prepares her to meet most of the needs enumerated above. It has certain fixed principles based on a wide general experience which should not be lost sight of while concentrating on the immediate needs of the moment:

(1) The basic training should be as general as possible.

(2) The professional training itself must be kept intact.

(3) The ethical and economic future welfare of the worker must be assured by an adequate preparation for the work.

2. How the education of the nurse could be better adapted to meet the community need:

This basic training, however, does not fit her for the education and teaching of the physically fit. Special

preparation is necessary for this work. She must prepare herself by means of practical training in special institutions or such connected with sanatoria and hospitals. She must also have some knowledge of the working conditions of the professions and trades under consideration. For all this, a course of six to eight months' classwork and practical experience will not be too long.

A special supplementary training is necessary for nursing in nervous and mental diseases.

In order for a trained nurse to take her part in combating infantile mortality from a social point of view, the nurse must have received additional training. She must take a course in social service work, and if she is to be prepared for child welfare work as well as for work among adults, a minimum of two years' training must be allowed.

A very small number will be able to qualify in all these different branches, with a maximum of four years' training. These graduates should not of course work in the rank and file, but will become leaders, principals and instructors of schools of nursing, etc., and will be responsible for the education of students.

But above all things it is absolutely essential that the basic training rest on a firm foundation, which in some countries lasts twenty-eight or even thirty-four months. After this, it is advisable to provide for a certain number of post-graduate courses, the length of these courses depending on the branch of specialisation chosen; anything of this kind being subject to social conditions which are constantly changing and progressing.



## *State Supervision in Schools of Nursing*

By **ADDA ELDREDGE**, Director of Nursing Education, Secretary of the State Board of Nurse Examiners, State Board of Health, Madison, Wisconsin, U.S.A.

The starting point in state supervision is the establishing of pleasant relations between the inspected school and the inspector. Inspection has helped to bring into the minds of all those connected with state supervision the necessity of getting as far away as possible from the old idea of inspection, that is, the looking for flaws, to the new idea of supervision, or expert advice. It may be said that to be real or lasting all improvement must come from within, though the impetus may come from without. The only way to make any impression upon schools of nursing and remove their faults is, as in the case of the public school, to make those responsible recognise the faults and desire something better. This applies not only to the superintendents of nurses or to matrons but to boards of trustees, hospital superintendents, motherhouses, instructors, supervisors and head nurses.

State supervision must set a minimum standard which must be maintained, and, of course, the person in charge must be responsible for the maintenance of these standards, so she must convince the different groups in the community of the soundness of her plans. Nothing that is unsound can last indefinitely. It will fail through its lack of foundation.

In the United States, we realise that we have many diverse interests concerned with the running of schools of nursing, as well as many states with different laws and standards, so that uniformity is difficult to obtain. What can be put in the law in one state cannot be put in another; what can be passed in one state is unconstitutional in another. One state is more advanced and therefore is more ready to accept changes. It is easy to understand

that different countries must have standards differing from each other owing to the difference in tradition and also in the position nursing occupies, although countries just establishing nursing ought to be able to start without some of our handicaps. I believe there are not in most countries the many different interests engaged in running hospitals and schools of nursing that we suffer from in the United States. Among these different interests we have the church denominations, all actuated by splendid motives, devoted to the care of the sick, but few of their members seeing the importance of the education of the nurse or able to visualise her as a student: involved in the financing of the hospital, most of them believe that the students should be there because of their economic value to the hospital and should be content to accept the crumbs which fall from the medical table.

Probably as a whole no group is so difficult to convince of the educational problem in nursing as is the medical profession, excepting, of course, the individual physicians who see eye to eye with the nurses. We acknowledge the splendid support given by this group. Still the rank and file of the doctors see nothing but what they want and are entirely indifferent to the exploitation of the student, anxious to use her during her training and then to cry out against her when graduated, for the doctors, we are told, demand student service in the hospitals. Some of the rank and file of medical men run so-called schools of nursing connected with small private and commercial hospitals, and are interested in the student for economic reasons. Besides these hospitals, there are endowed hospitals and

many not endowed but depending upon community chests, special drives, yearly gifts, for their very existence. The attitude of the boards of trustees is plainly shown in Miss Hall's paper on the Grading Committee's report, where she quoted the trustee who had read the report and said, "Of course we do not need to reduce our school because we are producing quality now, and, of course, small hospitals cannot afford to reduce their schools." If this is a true reaction of the trustee of a hospital connected with a university, as is the hospital referred to, we know it is increasingly true of other less well informed trustees of hospitals, not only in the United States but in every country where nursing has been established for any length of time, and where students have been depended upon to do the work of caring for the hospital patients. It is easy to see that our state supervisor of schools of nursing has a very definite and difficult programme of education in front of her, an educational programme for everybody connected with the school of nursing, either professionally or financially, either directly or indirectly. This person, variously designated as director of nursing education, educational director, inspector of schools, etc., must be a very well prepared person, and not only scholastically, for a degree is an asset only when and if backed by experience and ability to use her knowledge. She must possess kindness, sympathy, a real liking for people, open-mindedness and, shall I say, some of the earmarks of a statesman.

Perhaps I have used a great many words to say that this position requires education, or at least an educational point of view, and experience in various fields, tact and a sense of humour, a willingness to give and take, to laugh at oneself, to change one's mind. Needless to say, a woman of this type should be well paid. I believe that rather

than raise by law the standards for entrance to schools of nursing, we should take the money we would spend on attempting this end and place full time secretaries, directors, inspectors, whatever they are called, in those states which have none, and let the laws already on the statutes be enforced.

Let the state supervisor in her first inspection make a survey of existing conditions, being very lenient in judgment, very careful in pronouncement, until everything has been seen and she knows the best as well as the worst. After the facts have been collected, an analysis and comparison should be made with the required state or country standards and a point of departure be established or a reasonable minimum standard adopted.

Just briefly and from my own experience, let me say a safe place to begin is with the educational credits. These are generally very plainly stated in the law, or the rules which have the effect of law, and certainly no fault can be found with one for insisting that the school shall not admit a single student who has not these minimum requirements. If no one has previously checked these credits, it will be quite appalling to find how many students have been admitted on their own statement as to education, while the careful examination of credentials obtained directly from the school will show that they indeed spent the stated number of years in the secondary school, but never successfully completed even the one year usually required.

This state of affairs cannot be put right at once. But when the graduates of these schools are refused examination for registration or permits to practise until they have obtained the credits, the authorities of the school of nursing will be more careful. Let me say that the first group of graduates should be granted special permits if there is a compulsory law, as generally neither they nor the school have wilfully

transgressed. Afterwards we can make a rule that the school should not admit one student who does not satisfy the minimum requirement, and that if such students have been admitted they must be dropped out. If the school claims a certain standard and makes exceptions, the supervisor should list that school at the level of the exception made. If the school which requires the minimum of a secondary school preparation admits students who do not qualify, this method will prevent repetition of the offence.

The next step is the adoption of a reasonable minimum curriculum, giving the number of hours of instruction in each subject required. No school will be satisfied by reaching only the minimum in each subject.

Insistence is necessary on the recording of every hour of class work, on a distinction between class, lecture and laboratory, and on an exact record of the number of days spent in each department, with a rule for changing nursing days to calendar days so that records are true instead of conjectures. This method refers, of course, to small hospitals where patients are not segregated.

As for the four services in which basic experience is necessary, I think in every country we are agreed that a nurse must have experience in surgery, medicine, pediatrics and obstetrics, and that affiliation must be made to provide what is lacking in the home hospital. This must be done gradually if more than one service is missing.

We have found it desirable for every student to have an optional subject and suggest psychiatry, communicable diseases, tuberculosis and public health, obstetrical and operating room supervision, administration and teaching, not hoping to confine the above experience to a few students but looking forward to the time when all students will demand experience in these fields and when

the authorities of the school will be educated to a belief that they are necessary for all.

The preliminary course has been an important factor in standardising schools of nursing by making it possible to give the basic studies in a co-ordinate and proper sequence. It has emphasised the need for definite teaching and practice in preference to giving the untried student the care of the patient immediately on her entrance to the school, when she learns by the "trial and error" method at the patient's expense. It is fruitful as a standard of organisation, as necessitating prepared instructors and leading directly to the scholastic organisation of the entire three years.

Some of the manifest things the state supervisor can do is to get at the trustees, at the medical staff, and talk about what constitutes a good school, not their school but any school, and what is necessary for such a school.

The importance of a school of nursing committee cannot be over-emphasised. It gives the superintendent of nurses a backing, it is a group interested and concerned in the educational responsibilities of the school as well as in the hospital needs, a group which will bridge the gap between superintendents, which will have a policy for the school and which will assist the hospital trustees to understand the school requirements. This group is as necessary to the stability of a school of nursing as is the lay group to public health nursing. It will form the nucleus of an effective lay group interested in what the education of the nurse means to the community. Matrons often do not wish for this committee, desiring to be the last authority, but they are mistaken, and a board of trustees should insist upon appointing such a committee and seeing that it works. Such a committee can often adjust the misunderstandings which arise between the hospital and school authorities.

Many schools of nursing are not organised in the best sense of the word. The superintendent of nurses is in charge of the school of nursing but also of the department of nursing, which is one of the departments of the hospital; co-operation with the hospital superintendent is therefore essential. One is impressed on every visit by the amount of information which should be at hand on the superintendent's desk which has to be obtained from the general office or from the wards.

The state supervisor should be able to tell all superintendents what material and information they should have at hand; she should educate them to write reports, monthly and yearly, to present these reports before the hospital boards, in person if possible, or if not, to send a copy to each monthly meeting of the board and to file a copy in the training school archives, which show the progress of the school from day to day, so that a complete history of the school, its needs and accomplishments during her tenure of office can be found at any time. Too often, when the superintendent leaves, there is almost nothing left on file to guide her successor.

It is the manifest obligation of the state supervisor to collect all literature relating to schools of nursing, to keep in touch with all new ideas and improvements, to prepare proper forms for use in the schools, all teaching material and equipment, and to distribute these to the schools as fast as they can use them; from time to time to recommend books, pamphlets, magazines for the library, new equipment and methods of teaching and supervision.

To get good and new ideas from one school to another school, to stimulate interest, enthusiasm and progress in the schools, is a great responsibility — encouraging group nursing by students as leading to a deeper interest in the patient, encouraging case study for the same reason, advising and demonstrating

the correlation of theory and practice in the second and third years as well as in the first, recommending and if necessary requiring affiliations.

Go slowly with demands, make changes by suggestions, but suggestions which are continually repeated. Each year add something new to your suggestions, never let the nursing faculty "rest on their oars."

Encourage superintendents of nurses to believe that it will take time to establish a school and to bring it up to standard, that it will take from three to five years to accomplish anything lasting. It is wise to remember that it takes at least a year to make yourself trusted, another to get any real organisation, a third to interest the people of your community in your school, and at least two years to get the right people in the right positions; that you will have to stay for a year or two after you have accomplished these objects to hold things steady until you have educated your school of nursing committee and trustees to understand your aims and to appreciate what you have achieved in the way of growth and stability.

The state supervisor must realise that she cannot do much in one year or two, but that she must be patient with ignorance, indifference and even with the superintendent who likes her surroundings and will not suggest changes for fear of upsetting her own peaceful relations with the board, the woman who is so comfortable she does not wish to move on and therefore accepts undesirable conditions and deplores them only to the inspector, and very softly even then.

Remember that for schools to demand secondary education for students would require a great improvement in many institutions. Such students should expect to find educated and prepared people in all positions in the school (their education certainly not less than that demanded of the student).



State supervision of nursing should mean a general raising of standards, a general growth in knowledge and appreciation of nursing development, standards not only in the schools but in the community, an improvement in organisation, an improvement in the educational preparation, not only of students entering, but also of the nurses graduated, a greater interest shown by the public and a greater appreciation of the educational task. Ultimately, it should mean state aid for schools of nursing or endowment and co-operation between all classes of hospitals and sanatoria.

We have heard that some of the English nurses feel that a minimum curriculum should be demanded for every school. My reading of these rules and regulations, however, would cause me to say that the examination syllabus must in time create such a minimum curriculum, because the schools must see to it that their students cover the ground outlined if their graduates are to pass these examinations. The taking of the state examination in two parts, as provided for in England, must allow for the same weeding out of unsatisfactory students as the preliminary course does in the United States.

The principles followed in Sweden in regard to state supervision of nursing are rather different from those at present in practice in England and Wales. Sweden has not yet made any arrangement for the holding of state examinations, the examinations conducted by schools of nursing recognised by the state being accepted as an equivalent. The minimum curriculum is nothing more than that of England and Wales, outlined in detail, but in Sweden practically everything rests with inspection. The Superintendent of Registration is in constant correspondence and pays frequent visits to the twenty-nine state recognised schools. She is thus fully acquainted with all their problems and as a highly experienced nurse can give the best

possible advice when needed. Furthermore, being herself a member of the Royal Medical Board of Sweden, she has the opportunity of enlisting the interest of the most prominent members of the medical profession in all matters pertaining to nursing.

I feel a little diffident in speaking of what supervision is doing for Canada, but I believe that the same problem exists there that we have in the United States. The law in Ontario is administered under the Department of Health and provides for the inspection of schools for nurses, is responsible for the regulations governing schools for nurses in the province, and for the drafting of a curriculum for student nurses. It also keeps a register of the schools meeting the minimum requirements and arranges for such affiliations as may be necessary. It would seem to me that—perhaps with the exception of one other province in addition to Ontario—the suggestions as to supervision are not altogether inappropriate for the remaining seven Canadian provinces.

Time will not allow me to go into detail with regard to supervision in other countries; their customs and standards, also, can be discussed here with greater authority by the nurses coming from these countries. I should like to conclude, however, by stating my conviction that frequent inspection of schools of nursing by qualified nurses is one of the greatest essentials in nursing legislation. It seems to me that insufficient attention has perhaps been paid to this in the past. As mentioned above, in the U.S.A. all states do not provide for inspection, and if we turn to the world in general, only seven countries of the twenty-five that enforce their Nursing Act or State Regulations actually carry out inspection. Lastly, we notice that in one of these seven, namely Belgium, the office of inspector is held not by a nurse but by a member of the medical profession.

## *The Organisation of Post-Graduate Study in Nursing*

By RACHEL A. COX-DAVIES, President, College of Nursing, England.

For the sake of brevity and clearness I deal with The Organisation of Post-Graduate Study in Nursing under two headings:

1. The importance of post-graduate work as it affects the life of the graduate nurse (a) from an *educational standpoint*, and (b) from that of *character development*.

2. The method by which post-graduate work can most effectively be organised.

### I

(a) I take first the *need* and therefore the vital *importance* of post-graduate work from the *educational* point of view.

The ever-increasing advance of science and research in the medical and surgical treatment of the sick makes it essential that there should be a correspondingly ever-increasing advance in the educational opportunities available for the nursing profession, bearing in mind, as we ever must, the responsibility we have in our service to the nations of the world.

Educationally as well as vocationally we are dependent on our hospital training schools for not only providing the right type of student, but also, in the first instance, for educating her on those lines best qualified to enable her to take full advantage of opportunities available at a later stage in her career.

The subjects taken by the student nurse during the prescribed period of training suffice only to cover the essential and basic field of knowledge, in which every woman must become proficient if she is worthily to fulfil her mission to those whom she seeks to serve.

The increasing responsibility of the nursing profession in its service to the nation, its extension to every branch of preventive work, and the technical knowledge required, has

roused the interest of the great educational bodies and encouraged them to provide facilities for the higher education of nurses seeking the more responsible posts in these various fields.

It is only with such co-operation from the universities that it is possible to carry out effectively post-graduate work suitable for the varied responsibilities a trained nurse is called upon to undertake.

(b) *Character Development.* A trained, or graduate, nurse leaves her school with a whole field of knowledge waiting to be explored. She has so far received her impressions from a more or less limited horizon—her life has been of necessity one of rule and routine. Before she can take her place worthily, not only as a finished nurse but also as a citizen, she needs to enlarge her vision, to study if possible industrial and social conditions, giving her the wide outlook which will enable her to enter more fully into the life of the nation she seeks to serve.

### II

And now to go a little more in detail into the *organisation of post-graduate work*.

One common principle may probably be laid down as essential in all countries, namely—if a country is to provide effective post-graduate study, there must be a central body forming the liaison with the universities, by which suitable courses in the various branches of nursing and social service can be arranged.

In England we have such a central body in the College of Nursing, established in 1916, and now empowered by virtue of its Royal Charter to affiliate directly with the universities. Here more than 26,000 fully trained nurse members look to the college to unify the profession and advance their educational, social and economic interests.

Though not yet received as a unit of the university, we are working in close collaboration with Bedford College for Women and King's College for Women, both forming part of the University of London, and we look forward, in the no distant future, to becoming ourselves an integral part of the university, by establishing a Chair of Nursing.

Through this central body, the College of Nursing, courses are arranged in various branches of post-graduate education such as may be required by the individual nurse seeking to fit herself for public health work, social service or hospital administration.

Scholarships and loans are also given, to facilitate study and experience in other branches of nursing.

Courses in public health, followed at Bedford College, are arranged by a joint committee, whilst the College of Nursing is responsible for providing the practical experience in the various fields of public health work studied in these courses. This practical experience is not necessarily confined to London, but pupils are sent to centres in large provincial towns, to rural districts and even further afield, as occasion may require.

In England these courses of post-graduate training are recognised by the Ministry of Health as being essential for efficient service in the national field of preventive work, and grants are made to assist the students to take this training in recognised centres, of which the College of Nursing is one.

Here I may mention what is probably already well known to many gathered in this room—through the League of Red Cross Societies, graduates from many countries have been received in order to take this post-graduate training and so fit themselves to fill posts of high responsibility in their own country.

In addition to this public health course so briefly summarised here, there is the Sister Tutor Course, at King's College for Women, carrying with it scholarships open to compe-

tition and providing training for the specialised work of a sister tutor.

Individual training schools send pupils to attend these courses, and self-governing branches of the College of Nursing from time to time provide scholarships from their particular group.

Hospitals are gradually awakening to the responsibility of providing this specialised training to a graduate of their own school, and we look forward to the future when post-graduate study will be regarded as a necessary corollary to the prescribed period of training.

Since the inauguration, by the University of London, of the Diploma in Nursing, the College of Nursing has instituted courses to meet the needs of those who desire to qualify for the diploma in one of its many sections. Leeds University also grants a Diploma in Nursing requiring a short course of study at the university.

To sum up briefly—

The essential conditions required for the efficient organisation of post-graduate work would appear to be:

1. A central body sufficiently representative in numbers and strong enough in educational power to be capable of providing, on the one hand, the mouth-piece by which the trained nurse can make her needs known, and on the other, the necessary link with the universities.

2. Courses of training available through this central body, to enable the trained nurse to become conversant with the industrial and social conditions of those whom she will be required to serve.

3. The provision of scholarships available for those who require financial assistance to enable them to take advantage of these post-graduate courses, as also a loan fund, by which emergency expenditure can be facilitated.

4. A comprehensive scheme of travelling scholarships, which shall enable trained nurses to visit other countries and study methods prevailing therein.

## *Legislation in Nursing*

By E. M. MUSSON, Chairman, General Nursing Council of England and Wales

[In presenting a study on Legislation in Nursing, Miss Musson stated that some type of legislation has been passed in ninety-five countries or states, the vast majority of which became effective since 1900. The remainder of Miss Musson's paper, slightly abridged, is published herewith.—Editor.]

The fact that some kind of law exists, by which a basic standard can be enforced, has already done much, however, to improve the education of the nurses, and no country where such law, however faulty, has been in force even for a few years, would consent to return to the former state of things. Whatever form legislation takes, it can only lay down a basic standard, but human nature is such that once a minimum has been established, efforts will inevitably be made to improve upon it, and so it is in our profession. By individual and corporate effort nurses are striving, and will strive, to build up something better; the general average of nursing education is gradually being raised; colleges and universities are beginning to interest themselves in nursing education, to provide higher courses of study, and to offer diplomas and degrees, while the provision of scholarships may be anticipated for the assistance of nurses, such as are available for the members of other professions.

Perhaps the first effect of the passing of a law is to give to the pupil an incentive for study greater than existed before, but the most striking effect is the immediate improvement in teaching. It has been said that the real value of an examination is to test the teaching which a candidate has received. Whether that be true or not there is no doubt that the provision of a standard leads immediately to improvement, not only in numbers and ability of the teachers engaged, but in class rooms, equipment, and in the time devoted to lectures and study. The general public also begin to realise that a definite qualification has been established, and to

differentiate between the trained and the untrained woman.

Miss Musson pointed out that legislation obtained has not always been under Nurses' Registration Acts; other "legal enactments" in force at present are:

1. *Enactments under some Act having general powers, e.g.:*

Medical and Pharmacy Acts of South Africa.

Public Health Acts, Queensland.

General Powers Act of Northern and Central Australia.

Hospital Act and Charitable Institutions Act in Ontario. (Two of these, Queensland and Ontario, have now obtained Nurses' Registration Acts.)

2. The incorporation or registration by-law of a Nurses' Association giving it the right to register nurses.

3. *Decrees, Arrêts* (orders given by a king, a tribunal, or other legal authority) establishing a state diploma or certificate.

4. *Licensing Act.* Authorisation or permit to practise, involving payment of a tax to the state.

The type of legislation in force depends on many factors, the general position of women in the country, the stage to which nursing has advanced, and the degree to which nurses are organised, as well as on national and racial characteristics. Generally speaking, the *Registration Acts* proper, setting up a statutory body, are in force in those countries where nursing organisation is advanced, and they usually confer a greater representation of nurses than is the case on those councils set up under a more general law. For instance, under the *Nurses' Registration Act* in England and Wales, 16/25ths of



the council must be nurses elected by the nurses on the register, the remaining nine being nominated by the Privy Council and Government Departments, and in actual practice have been members of the medical profession and the laity. Under the *Medical and Pharmacy Acts* in force in the Union of South Africa, only two persons are elected by the nurses, midwives and masseurs registered and resident in the Union, i.e. in the five states, Cape Province, Natal, Orange Free State, Transvaal and Territory of S.W. Africa, while 14 medical men, 4 dentists and 2 lay people form the rest of the council. And again, in the Territories of Northern Australia and Central Australia, under General Powers Acts, "Nurses' Boards" have been set up to appoint examiners, fix standards, register or annul certificates of registration, etc., and these boards are composed of the government resident, the chief medical officer, and a third person, who in the case of Northern Australia is the chief clerk and accountant, and in the case of Central Australia, one to be appointed by the minister. Two of these form a quorum.

These territories are very large, contain great tracts of desert and uncultivated land. The population is very scattered, and no doubt the need for regulating the training is very great, but it is to be hoped that this entirely lay board will obtain the help and advice of the A.T.N.A. in making their regulations.

In the United States of America, we find a similar inequality as regards the governing body or "Boards of Examiners." Whereas, in some states these are composed entirely of nurses, in others they are composed entirely of medical men, and in others of a varying proportion of the two.

The principle of election of nurses' representatives by the nurses themselves is the one which prevails most in the various states of the British Empire, while within the U.S.A. the board is usually appointed by the

governor or by a university, the Nurses' Association having the right of nomination for appointment of the nurse representatives.

The only states which have registration under the next class (2) are the nine provinces of this great Dominion of Canada, where the Nurses' Association is registered or incorporated by the state, and the individual nurse is registered by the association. There are no doubt some advantages in such an arrangement, but there are also disadvantages in combining the functions of a statutory body with those of a voluntary association. It certainly ensures the representation of nurses on the governing body, and gives them control of their own register and of disciplinary matters, but the powers appear to be limited to those relating to registration, those relating to education and examination being usually relegated to other bodies, namely, the universities. Such arrangements would hardly prove successful in states where there are several associations holding divergent views. While a statutory body has a limited scope but considerable legal power, a voluntary association has less legal power, but a very wide scope, as it can concern itself with any or all of the varied activities and the various sides of a nurse's life and work. It has also the duty of acting as the corporate voice of its members—a function which is of great value not only to the nurses, but also to the statutory body, when such exists separately, whether the voice be raised in criticism or in support. It is by means of voluntary associations that the general public can best be informed of nurses' progress and of their needs.

The next class (3), namely, the institution by-law of an examination qualifying for a certificate or diploma obtains chiefly, if we except Germany, in countries where modern nursing is still more or less in its infancy, and where the pioneers have still to contend with many difficulties. The

"Decrees" or "Arrets" under which these come into force are more easily altered or amended than are Acts of Parliament, and to begin with some such enactment is probably the wisest course to pursue in those countries, until there are a sufficient number of nurses holding the state certificate or diploma, to form a strong association, and until public opinion is more instructed as to the value to the state of a sound and well-trained nursing service.

In regard to the last class (4) it is worth noting that while one or two states require a nurse to take out a license to practise in addition to being registered, only one country (Italy) has begun its general legislation for nurses by means of a Licensing Act.

It will be understood that some who have for years been struggling to promote training on modern lines in that country, especially in the schools founded by H.M. Queen Elena, may have felt some apprehension when in 1927, nurses were included in a law requiring that a special permit must be obtained by "anyone wishing to exercise the art of maker of false teeth, optician, orthopaedist, truss maker, or nurse, the last category including head bath attendants of hydrotherapeutic establishments, masseurs and masseuses." Regulations for the carrying out of the law to be issued by the Ministers of the Interior and Public Instruction.

Remembering the small proportion of trained nurses, it was feared that such a measure might lower rather than raise the standard, by regularising the practice of large numbers of untrained nurses.

Inasmuch, however, as those who had habitually exercised for at least two years the professions and special occupations mentioned above were required within one year from the entry into force of the law to give proof of their efficiency before an examining commission, in accordance with the provisions to be laid down in the regulations, and that nurses

in the employ of hospitals are required within nine years to obtain the permit or certificate, it would seem that improvement must take place, owing to the necessary provision of definite courses of study, and to a greater incentive to learn on the part of the nurse.

I believe that nurses in every country must work out their own salvation, and this way of beginning may prove to be that which is best suited to the Italian character, and we shall await with interest the advance which we expect will be made in Italian nursing in the course of the present decade. This Act is far more drastic in its provisions than any other Act relating to the practice of nursing, as it is a punishable offence not only to practise nursing without a permit, but "in case of repetition of an offence the punishment is detention from 15 to 30 days and a fine of from Lire 500-1000." Any materials used or intended to be used for "committing the offence" to be confiscated.

Anyone with regular authorisation to practise one of the medical professions or one of the auxiliary arts covered by the present law, who lends in whatever manner his name or his aid with a view to permitting or facilitating the offence mentioned in the preceding article is also liable to the punishments prescribed.

The sentence involves the suspension of the exercise of the medical profession or of the auxiliary arts for a period of time equal to that of the term inflicted.

The duties under the Nurses' Registration Acts vary, but usually include the following duties:

1. To make rules and regulations and prescribe all conditions not laid down in the Act.
2. To approve training schools.
3. To draw up syllabus of instruction.
4. To place names on the register and to keep the same.
5. To remove names under certain conditions.
6. To deal with finance.

It is when considering the question of reciprocal agreements between the different countries, to enable registered nurses from one country to register without re-examination in another, that the great diversity of the legal enactments becomes evident. When it is realised that in the United States of America, so closely allied and situated so near together, it has not been found possible to arrange for universal reciprocity, it is not surprising that agreements between the widely scattered Dominions forming the British Empire are slow in materialising. One difficulty we have not been faced with, which is, that with one exception, the Acts in force in the British Empire require a three years' course of training, which is not the case in all the U.S.A. A difficulty which has arisen is that practically all the Overseas Dominions recognise smaller hospitals as training schools than we do in the Mother Country. We have to bear in mind the different conditions which obtain. England is a small, very thickly populated country, most of the Overseas Dominions are very large and thinly populated countries, and it has been found necessary to exercise some "give and take."

Some states include under a special category, classes of nurses who could not be accepted on a register of trained nurses, no doubt deeming it wise to bring these classes under supervision. In making an agreement for reciprocity with countries where this is the case, such classes are of course excluded. Some conditions are usually laid down also in regard to nurses registered without examination on the passing of an Act.

Again, the term "General Hospital" is found to be variously interpreted. The General Nursing Council of England and Wales has found it necessary to adopt a formula when making reciprocal agreements. A general hospital is defined as one which admits men, women and children, and gives instruction in the

four main services: medical, surgical, gynaecological and children's diseases. General training may be given in one general hospital recognised as a complete training school, or in recognised affiliated or associated hospitals which together give instruction in the above named services.

In some countries "obstetrics" are added to the above. In Great Britain, owing to the existence for many years of the Central Midwives' Board, nurses intending to practise in this branch take a further six months training and pass a midwifery examination in addition to their general training and examination. It is realised that the midwifery certificate, as well as the general certificate, must be produced when applying for registration in those states where the general training includes obstetrics.

In some states, nurses who have received special training in one branch only, are included in the "General" register. In Great Britain, Scotland, Northern Ireland and in the Irish Free State, the councils are required to keep, besides the general register, supplementary registers for male nurses, mental nurses, nurses for mental defectives, fever nurses, sick children's nurses. Reciprocity can only be arranged for these if a similar supplementary register exists in the Dominion concerned, and conversely, any nurse registered on a general register of any state after "Special" training can only be admitted by reciprocity to the appropriate supplementary registers in the British Isles.

The standardisation of nursing training throughout the world is not in my opinion possible at the present time, nor will the establishment of even a minimum standard be possible for many years to come. But nothing but good can come from the sympathetic study of the conditions in other countries and from open and candid discussion at such meetings as these.

## *Developments in the Public Health Field*

By PROFESSOR G. B. ROATTA, Director of Dispensaries, Florence, Italy

When the International Council of Nurses did me the honour of inviting me to speak at this Congress on Public Health Developments, before all things it became necessary for me to find an answer to a question: What unit of measure is at our disposal by which we can judge of the progress of this development?

Every question is capable of more than one answer, which answers in themselves are often contradictory, according to the point of view from which we attack them.

The unit of measure which at first sight seems the most reliable is that of statistics.

Nevertheless, statistics, with their apparent precision, and on account of this same mathematical precision, are more likely than anything else to lead us to mistaken conclusions.

To begin with, medical statistics are just beginning to assume a scientific form, and the figures furnished to us by different countries cannot always be compared with one another. For many illnesses we find only the figures relating to the death-rate. These figures are very far from even approximately giving the march of the diseases to which they relate. For example, tuberculosis.

Certain diseases which are essentially preventable, that is, susceptible to control by an efficient sanitary organisation, are greatly influenced by other factors. For example, typhoid fever assumes a varying intensity in a country in accordance with the different climatic conditions of the different parts of this same country.

In the United States of America the southern states give a heavier death rate from typhoid fever than the northern. These rates are somewhat similar to those of Italy and Spain. The rates for Japan and those of the State of San Paulo, in the southern part of Brazil, are almost identical with those of the above-mentioned countries. Other factors than those

of hygienic organisation may influence Public Health—for example, economic and political conditions.

The Great War has furnished a striking example of these influences, showing them to us as under a magnifying glass.

In other cases the progress of therapeutics may modify the epidemiology of some diseases to a considerable extent, independently of any hygienic or prophylactic measure. According to some writers this would appear to be the case in syphilis. The death rate from diphtheria has been greatly influenced by the serum treatment.

Another factor has to be taken into account, namely, the changes undergone by different diseases in different epochs.

This fact has been already emphasised by old medical writers and first of all by Sydenham, in his "Epidemic Constitution". That is what the French writers call "le genie epidemique".

For some illnesses, one may admit the influence of therapeutics, as we have already seen may be the case for syphilis. For others, one may advocate the difference in the condition of life, as in gout and chlorosis, which are rapidly decreasing since the end of the last century.

But for others, we must admit a change in the nature of the illness itself. This seems to be the case for scarlet fever. A hundred years ago, this illness was a very mild one. Fifty years later it became very serious, and it has now resumed again its earlier character, while its incidence is practically the same.

But a much more important objection can be made to the consideration of medical statistics alone, in judging Public Health development: that is—up to now they may tell us to a certain extent what is the state of disease, but they tell us nothing about the state of health.



A disease—I mean a disease which kills, and statistics deal chiefly with this—when it does not assume the sweeping waves of the great epidemics of the Middle Ages, is socially much less important than those indeterminate conditions which favour the production of individuals physically and mentally deficient. Medical statistics give us no information about such conditions, which are not those of illness, neither are they those of health. At the most they allow us to form suppositions based on the prevalence of certain groups of diseases of a specially social character, like tuberculosis, syphilis or alcoholism.

Perhaps it is altogether wrong to seek for the explanation of Public Health improvement in diseases and death rate statistics, Hygiene being the Science of Health, and by health I mean the harmonious development of mind and body.

The prevention of disease is therefore only a means to an end—one of the means.

There exist an infinity of other factors of moral, intellectual, aesthetic and economic character, which work together in an equally important degree to this end, influencing no less than the prevention of disease the formation of the marvellous being which we call Man.

We will, therefore, leave to one side the statistics of disease, which at best can only give us limited and one-sided information, and seek for the answer in the consideration of Public Health itself: how, with what weapons, with what mentality, with what aim and by what means, Hygiene seeks to attain the ideal conditions of which we have spoken.

In other words, are its means and its mentality adequate? Public Health proceeds from medicine—the Art of Healing; and from sociology—the science which studies the relations between social conditions. One could almost say that Public Health, with medicine as starting point, tends towards, or is pushed towards sociology.

Passing in review the history of Public Health, we note in it an alteration of medical and social influence.

In ancient times the social tendency prevailed; it is sufficient to call to mind the hygienic laws of the early peoples. We find that they often assumed a religious character, and those precepts which were more purely medical were strictly bound up with a social and political system, aiming towards the purity and robustness of the people, and restraining the decadence of social customs.

The laws of Moses are typical from this point of view, and these remain even to our day, passing through the Christian era.

In the Middle Ages we may say that all ideas of Hygiene were contained in ecclesiastical dicta: times of fasting, periodical restrictions in the use of certain foods, especially meat; the limitation of matrimony among relatives; the minimum age at which matrimony might take place . . . these, and but little more, were the medical impedimenta of the Middle Ages. Sickness was a manifestation of divine law, a means by which God tried the faith and the virtue of believers, and chastised the wicked. It was a heroic experience by which saints attained to the glory of Paradise. And so the mysticism of this epoch manifested itself in the care of the sick and the poor. But this assistance limited itself to the necessities of the moment, ignored the past and did not think of the morrow.

It was the literal interpretation of the great precepts of the church: "Visit the sick," "Feed the hungry," for in centuries not very far back, hunger was one of the most formidable of diseases, and famine epidemics, if I may say so, only too often preceded epidemics of plague.

From this mystical conception of the need of caring for the sick, hospitals took their origin, and this vast chain of institutions links the Middle Ages with our own times. The only exception to this poor Public Health programme is shown by a few commercial and industrial communities; first of all the Italian Communes, where we see the first attempt to establish an efficient Public Health system.

We shall be obliged to return to this idea of the influence of commerce and

of industry on the development of Public Health. In this perhaps we shall find an explanation and a justification for the progress in this field which we note in our own time, especially in industrial countries, and to the difference in Public Health conception in Anglo-Saxon (that is industrial) and Latin countries, which only now begin to emerge from rural economy.

But at the approach of the 19th century we find a complete change in the Public Health Field.

This is a great moment in the intellectual history of mankind. Free thought and free speech, the sentiments of moral and intellectual dignity which follow on the French and American Revolutions manifest themselves in a decided reaction to metaphysics.

The human spirit, suddenly freed from the trammels which had long imprisoned it, finds once more the fresh vigour, the audacity, the scientific curiosity of the early Greek philosophers before Socrates, but with the background of thirty centuries of experience.

All at once the battles which past generations had given up as lost shine out as victories. Scientific thought, which in the 17th and 18th centuries was a privilege of few great spirits, now becomes a common possession. In less than a century scientific thought and its application is revolutionised.

Our civilisation is very young.

It is difficult for us to realise that Pasteur, the man who definitely destroyed the theory of spontaneous generation, and by means of bacteriology created a new science, unveiling the mysteries of infectious diseases, died only thirty-four years ago. Many of us were already born, or even well on in life, when the centuries-old edifice of traditional medicine fell to the ground, and from the ruins of the ancient theories and dogmas arose the solid construction of experimental science.

The history of science at this decisive turning point has the lightning flashes and the incisive language of great historical dramas.

It was only in 1881—less than half a century ago, that the experiment on anthrax took place at Pouilly-le-Fort. Pouilly-le-Fort—name as memorable in history as that of the greatest battle where the fate of nations was decided.

Fifty sheep had been inoculated with a virulent anthrax culture: of these twenty-five had been previously vaccinated and twenty-five had not.

On June 2nd, Pasteur, with Chamberland and du Roux, entered the farm, in the midst of a scoffing crowd, stirred up to animosity by fiercely adverse press agents, all gathered together to witness his defeat under the sceptical eyes of scientific officials.

Twenty-five unvaccinated sheep lay on the ground, twenty-two already dead, the others dying, while the twenty-five vaccinated ones were on their feet, lusty and strong.

The crowd of veterinaries, of farmers, of those who had come to see, moved to enthusiasm by an almost reverent admiration, applaud and applaud again. Rossignol, incredulous veterinary that he was, who had encouraged the experiment in order to demolish Pasteur's theories, stammers—conscience-stricken—"Master, can you forgive my unbelief"?

To find a parallel one must go back to gospel times, where through the action of miracles men are brought to a true faith.

Never was the dominion of medicine greater and more unquestioned, not even in remote times, when, as a sacred mystery, healing took place in secluded recesses of the temples. It seems now as if a new religion has arisen on the horizon of humanity.

The human body unveils its most intimate secrets: disease displays its inmost mysteries.

The great epidemics, which for centuries had invaded Europe, annihilating the population, irresistible in their fearful progress as the barbarian hordes that submerged Roman civilisation, are quelled for ever.

Infectious diseases like typhoid, having displayed their cause, are attacked at their origin; others, like diphtheria, are victoriously conquered

when they have already invaded the body. The tiny organisms that for centuries had so fiercely attacked mankind are at last discovered; they are reduced to slavery, and become docile instruments of healing and prevention of those diseases of which before they were the cause.

One further step, and man is made immune to infection, as the gods of Homer made their heroes invulnerable.

And now for a moment Man thinks himself Lord of Life and Death. The crucible of a laboratory seems to contain the destiny of man. The famous *boutade* dates from this time; virtue and vice are the result of a chemical reaction, as sulphuric acid.

This exuberant scientific youth pervades all intellectual and artistic manifestations.

In philosophy we have Positivism; in Art, Realism.

Public Health too is entirely dominated by the new scientific discoveries, and Man is considered mainly as a possible receptacle of infectious disease. The officer of Public Health now felt himself a little god, able to control from his laboratory the march of deadly disease. He admired with a rational admiration the French Revolution that by political liberty had made possible so much progress in the field of science; but he ignored the great moral revolution which, without noise and without victims, had been accomplished in England in the last years of the 18th and the first years of the 19th century.

We don't realise how young—how very young—is our civilisation, what we call our civilisation—self-respect, justice, sympathy with our fellow-creatures, feelings of responsibility and of co-operation for the well-being of the masses.

It is a new idea in the history of humanity. Three great factors work together to bring forward these new ideals.

1. In the spiritual world, the cool correctness of classicism gives way to romanticism; the joy and the sorrow of the human being, his sufferings and his enthusiasm, invade literature and art.

2. The religious revival which was the inspiration of an effort to remedy the guilt, the ignorance, the physical suffering, the social degradation of the profligate and the poor. (Sir Malcolm Morris.)

3. Industrialism. From the hygienic point of view one of the most striking effects of industrialism has been the alteration brought into the family unit. In rural countries the family is still the little world that it has been for all time, where under the same roof we find the man who provides for the nourishment and assures the protection—workman, hunter, soldier—while the woman sees to all the home-craft and by a long tradition of inheritance is a born nurse, cook, and child educator.

In industrial countries, instead women become wage earners as well as men, which leaves a gap to be filled and the necessity for well-organised social work. Well-organised, because industrialism means efficiency in men and in methods. It means to get the best results with the minimum of effort; it means to get to the root of things.

Sarah Gamp was not human, her morality was perhaps not very high, and above all she was not efficient. She was an economic mistake before being a moral nuisance.

In the Diary of Florence Nightingale there are a few very striking lines. On relating a visit to the historian Sismondi in Geneva, she says, "All Sismondi's political economy seems to be founded on the overflowing kindness of his heart. He gives to old beggars from principle, to young from habit." We feel quite sure she does not approve of this overflowing of the heart over political economy.

Another factor we owe to Industrialism is the art of persuasion and advertising. And that is why we find such a difference between the Public Health organisations in industrial and agricultural countries. In the one the law and the policeman; in the other the seeking of the spontaneous collaboration of the public through specialised agents (Public Health Nurses).

This may explain some difference in the results attained. For instance, the diminution of tuberculosis, a typical social disease, is greatest in industrial countries like the U.S.A., where there is a highly developed Public Health Nurses' organisation.

On the other hand, we find that infectious diseases of a more strictly medical character are efficaciously checked wherever there is sufficient medical preparation and official state control.

Take for instance diphtheria. The difference in mortality from this disease in Europe seems to be due to the promptitude with which serum is administered. In Italy it is highest in the mountain provinces in the centre of the country.

Since 1921 there has been in Italy but a single case of death from small-pox, and the illness itself is very rare. In the first four months of this year there have been but two cases, and these were imported from outside.

Puerperal fever, an eminently medical disease, gives us a minimum of mortality—nine deaths in 10,000 women in childbirth. Sweden alone in all Europe shows lower figures (in the three years 1911-1913).

Let us go back to tuberculosis. In Italy the mortality from this illness has not greatly changed in the last fifty years, and what improvement is noted is chiefly in cases of a non-pulmonary type which, as we know, are more easily controlled by curative treatment; while the mortality from malaria drops in the same period from 59.5 to 6.7. From a social point of view, malaria stands between tuberculosis and diphtheria. The campaign against this illness needs a good deal of collaboration from the public; but the evidence of the infection is of much easier demonstration than in tuberculosis, and therapeutic measures much more efficacious and for this reason much more easily understood. Therefore I think we are authorised in saying the Anglo-Saxon Public Health system will show itself at its best in all the illnesses where medical power is weakest, and the social conditions and public mentality more important.

There is only one danger, that is, in their zeal for the good of humanity the Public Health workers don't overdo it. That means going back to the rural Public Health system of coercion and imposition. In some ways the Public Health system movement seems to have got to a crucial point, which reminds us of the situation of religion in the Middle Ages, when believers thought themselves justified in imposing their creed by fire and sword.

No ideal, however great and however generous in its conception, can dispense with the conscientious and willing collaboration of the public.

A striking testimony of this comes to us from Germany, where the insurance system is the oldest and the most complete. In a recent book, by Dr. E. Liek, we read:

"In seeking to cover the various risks arising from sickness, accidents, disablement, unemployment, etc., social insurance schemes have been the cause of the moral deterioration of the German people, have taken from the working classes the love of work, have given birth to a system of exploitation of disease—both real and imaginary—have driven many workmen to seek in lengthy lawsuits compensation or the recovery of their wages—have, in a word, vulgarised and cheapened the medical profession."

Maybe there is exaggeration in this statement, but even by making due allowance, we can always take it as a warning against the danger of accelerating progress by law.

The great feature of Public Health will always be the human character, and the history of nations shows plainly that human character does not progress in proportion to intelligence, and moral conquests are always behind intellectual ones.

Another warning comes to us from England. E. D. Simon, in a recent study on the subject "How to Abolish the Slums," pointed out the deteriorating effect of the Slum Mind in many of the dwellers in houses which were in themselves structurally decent. His own figures indicate that this may be a debasing factor in the order of from 12 to 25%, even in a good housing



scheme. If these figures are correct, they demonstrate that from 12 to 25% of one of the most civilised populations, show alarming anti-social characteristics. Figures like these are more likely to give us an adequate idea of what has to be done, than statistics of illness and death rates, because they inform us of the moral and material conditions of the living man, and show us the weakest point of our front, that is, education—moral as well as physical. *And education must be started with the child.*

#### CONDITIONS OF CHILDHOOD

Unluckily our experience with children is too recent. Only in these last years reports from medical school inspectors have begun to give us a fair idea of the real condition of our children. It is quite safe to say that from one-third to two-thirds of the school children need medical attention; and, of course, we do not take into consideration those who do not enter school because their health is too seriously impaired.

They are not small ailments which we find recorded. Certainly we do not find sensational words like diphtheria or scarlet fever: very seldom do we find even tuberculosis. The diseases or complaints which we find may sound unimportant to the general public: general debility, belated rickets, catarrhal or neuropathic tendencies, diseases of the ear, nose or throat, adenoids, decay of temporary teeth, etc. These which are the most common defects of school children (and all children of our day are school children) are of a constitutional character, which means they stand for a degenerative process. They are the signs of a deeper constitutional unfitness, sometimes hereditary but more often due to something lacking in their bringing up.

So these are not defects which can be put right once for all, but they give just cause for grave anxiety for the future. In countries such as England, where these records cover some years, a slight improvement is noticeable, but it is slight and slow!

The problem is most complicated and difficult to deal with. It is easy to start a campaign—say, for certain

vaccinations. We can oppose the terror of death to a harmless inoculation that can be performed in a few seconds and that is the end of it. By the emotional feelings stirred by a well conducted public health campaign, we may hope to check some one or other disease, but this will neither give us the conquest of health nor allow health to be permanently maintained.

As George Newman warns us, in one of his most memorable reports: "Health is not an artificial accomplishment, quickly acquired and easily maintained. It is a development of body and mind; a growth, slow in process; a habit, broad-based upon heredity and nurture; a balance of moderation in all things, a harmony of a sound mind in a sound body, good nutrition combined with steady nervous regulation."

#### IMPROVEMENT OF MAN HIMSELF

We all carry through life—on our soul and on our body—the scars of early wounds, which may develop later on into illness or anti-social tendencies—slum minds, alcoholic minds, careless minds, these are the pit-falls in our way which prevent us from going on. We can trace the origin of all of them in childhood; they grow as life goes on, and throw their shadows over the coming generations.

We have advanced far, very far, from the ingenuous ideals of some fifty years ago when public health consisted almost exclusively in fighting contagious diseases, and in securing healthy environment. Now that this dream is almost realised—in many countries at least—we perceive that what remains for us to do is to improve man himself.

And that is why, when you asked me to speak on the developments in the public health field, I thought I could not point out a higher aim or a way to a more efficient conquest than the right education of the new generation, *the making of the citizen*, considering that all satisfactory development in the public health field depends upon the comprehension of the following principle: "The economic value of a population is in direct ratio to its intellectual, moral, and physical well-being."

## *The Red Cross Nursing Programme*

By Mrs. MAYNARD L. CARTER,

Chief, Division of Nursing, League of Red Cross Societies

To outline the Red Cross Nursing Programme, the object of my paper, demands a simple statement of fact, which I will endeavour to present as briefly as possible, trying at the same time to infuse into it some of the spirit and enthusiasm so characteristic of the Red Cross. The historical aspect has so many times been referred to in recent papers and reports that it is scarcely necessary to touch upon it in this paper; it is sufficient, therefore, to introduce the subject with a very brief account of the more recent events which have taken place in the Red Cross Nursing world, and which cannot but have a very considerable influence upon its programme.

Of these, the most important is the XIIIth International Red Cross Conference, held at the Hague in 1928, when certain joint recommendations on nursing presented by the League of Red Cross Societies and the International Red Cross Committee were approved, and which one may consider as being the basis of the Red Cross Nursing Programme.

The second important event was the meeting of the Board of Governors of the League, held at the Hague at the same time as the XIIIth Conference, when a resolution was passed providing for the appointment of technical advisors to the League in matters relating to its work, including nursing. This resolution provided for the appointment of a group of nurses who would take the place of the Nursing Advisory Board, which hitherto had guided the League in its nursing policy, and which had rendered such invaluable service. The problem of the selection of advisors in nursing was solved by the Red Cross nurses themselves at a meeting called in Paris in July of last year, when a recommendation was passed that the selection be made from nurses engaged in Red Cross work, and

that it be made with due consideration to the ethnic grouping and the degree of development of nursing organisation in the different countries, and that it include representatives of the English-speaking, the Latin, German-speaking countries, countries having recently organised nursing services, central European and oriental countries. In addition, the meeting recommended the inclusion of a representative of the Red Cross Society of the country in which the meeting of this group might be held; and a nurse delegate of the International Red Cross Committee. In order to secure a close co-operation with the professional nurses' associations on all technical questions, the meeting advocated that a representative of the International Council of Nurses be nominated.

This recommendation was approved by the Board of Governors of the League, subject to its general resolution on the matter. The nominations were approved by the Executive Committee at its meeting in April, 1929. For the time being, therefore, the future nursing policy of the League will be guided by Miss Elizabeth Fox (American Red Cross), Marchesa Targiani Giunti (Italian Red Cross), Frau Oberin von Freyhold (German Red Cross), Miss Messolora (Greek Red Cross), Madame Ibranyi (Hungarian Red Cross), Miss Wu (Chinese Red Cross), Madame Chaponniere-Chaix (International Red Cross Committee), and a representative of the International Council of Nurses.

A glance down this list shows that it is made up of women with wide experience in nursing and Red Cross work and thoroughly conversant with the problems confronting Red Cross Societies. The inclusion of a representative of the International Council of Nurses is evidence of the high standard of nursing which the Red Cross Societies have set for themselves, and

the earnest desire on the part of these Societies for the closest collaboration with the professional nurses' associations in the development of their work.

The ten recommendations approved by the XIIIth Conference were presented jointly by the League of Red Cross Societies and the International Red Cross Committee. They cover most of the activities in which Red Cross Societies are engaged, and while few are undertaking them all, several Red Cross Societies are undertaking many of them, and for the purpose of this paper they may be taken as the basis of the Red Cross Nursing Programme.

The first deals with the question of organisation and the formation of a Nursing Division under the direction of a qualified nurse, who shall be responsible for directing the nursing activities of the Red Cross Societies assisted by a Nursing Advisory Committee composed of persons qualified to advise on nursing matters. . . .

It is impossible to lay down any hard and fast rule; one has to consider the history of the development of the Red Cross Society, and the stage of development of nursing in the country generally, but experience leads one to believe and it was certainly the conviction of the Red Cross nurses who formulated this recommendation, that the most satisfactory way of building up a sound Red Cross Nursing Service is by the creation, by each Red Cross Society of a Nursing Division, under the direction of a highly-qualified professional nurse; and the word professional is used here to denote the nurse who has the highest accepted standard of training of her own country, whether she be receiving remuneration for her services, or works as a volunteer.

Recommendations two and three deal with the training of nurses by the Red Cross, and the establishment of schools for this purpose. They lay emphasis on the need for a high standard, urging Red Cross Societies to base their professional training on a thorough course of study. They emphasise the importance of long practical training in addition to theo-

retical study, and encourage collaboration with the professional nurses' associations for this purpose.

The duty of training nurses was laid upon the Red Cross Societies by the Geneva Convention, and this has been undertaken by certain societies since that time. In many countries, amongst which we can cite such examples as Japan, Greece, Latvia, France, Czechoslovakia, Yugoslavia, and Bulgaria, it is the Red Cross which has taken the initiative in the training of the nurse, and it is the Red Cross which has been the inspiration behind its development—a thing which has not always been fully appreciated. Whether it is rightly the responsibility of the Red Cross, or that of the Government, to undertake the training of the nurse is not a question for discussion here. The fact remains that Red Cross Societies are undertaking the training of nurses, that they are in most instances promoting high standards, and that it forms a very important activity in their programmes. It is the responsibility of the Nursing Division of the League, therefore, to give them every possible assistance within its power.

Miss Noyes, in her paper read at the Conference of the International Council of Nurses in Geneva, pointed out that there is nothing incompatible with the co-operation between the Red Cross nursing services of a country and the professional nurses' associations, and that in many countries it is carried out successfully. Examples of this are to be found in (1) Finland, where the Red Cross has practically placed its nursing policy in the hands of the national nurses' associations, the two Presidents forming with a nurse member of the Central Committee of the Red Cross a small Nursing Advisory Committee of three; (2) Great Britain, where the Red Cross has always collaborated closely with the College of Nursing, which owed its origin to the initiative of certain members of the British Red Cross; and (3) France, where the Red Cross Societies have representation on the Board of the National Association of Professional Nurses of France.

Difficulties have undoubtedly arisen in some countries which have hampered co-operation, due perhaps in the past to some lack of understanding on the part of the Red Cross Societies of the necessity for the professional training of the nurse. This can be well understood when one takes into consideration the history of a country, the stage of development of nursing, the position of women, an ever-important factor, and the rapid development of the Red Cross, confronted in many instances with immense responsibilities. On the other hand, the professional nurse, in confining herself as she sometimes has done, to narrow professional interests, has failed to appreciate fully the immense obligations which the Red Cross has been called upon to fulfill. The promotion of short courses for nurses, and the launching of nursing activities without adequate supervision, have led in the past to a certain bitterness of feeling which still lingers, and which can be well understood when one considers the long struggle for professional recognition which the nurse has had to face, and still has to face in some countries. However, in the whole field of Red Cross Nursing these are but a few isolated instances; the tendency is more and more towards understanding and closer collaboration and one finds as a result a more just appreciation of the great contribution made by the Red Cross to the development of nursing throughout the world, a contribution unequalled by any other single institution.

Recommendation four relates to the question of diplomas and encourages the granting of diplomas by the Red Cross Societies, corresponding to the degree of training received; in other words, it encourages Red Cross Societies to draw an even greater distinction than heretofore between the certificates given to the fully-trained nurse, and the auxiliary group.

Recommendation five authorises the League in conjunction with the International Red Cross Committee to study the best methods of enrollment of the trained nurse, and of recruiting and

training the auxiliary worker, and recommends that Red Cross Societies enroll these two groups, the two to form a strong disciplined corps, ready to be called upon in time of need.

The Geneva Convention also laid this obligation upon Red Cross Societies, and there is probably no recommendation which is of greater importance, for the enrollment of the nurse and the training and enrollment of the auxiliary worker is essentially a function of the Red Cross, and worthy of this special study being made. Most Red Cross Societies have undertaken this obligation laid upon them, and have instituted some system of enrollment of the trained nurse and auxiliary worker or "volunteer nurse" as she is so often called.

The need for a large, well-trained, well-disciplined auxiliary group to supplement the trained nurses was proved over and over again during the War, even countries with the most well-developed, highly-organised nursing services being dependent upon the "V.A.D." or "Volunteer Nurse". During the War Great Britain, which has now approximately 50,000 registered nurses in the country, had at that time army and navy and Red Cross nursing services and reserves numbering approximately 29,000 nurses, and still had to call upon a Red Cross auxiliary group of 100,000 members; even then it was impossible to ensure adequate care for the civil population of the country.

In countries where professional nursing has been slow in its development, the "volunteer nurse" has been an indispensable factor in time of war or disaster. Her training has been undertaken with no other motive than to serve her country, and it has often involved considerable personal sacrifice. During the Great War, without her many a soldier would have gone uncared for, and when the history of Red Cross nursing comes to be written, full justice will be paid to her. Her training and enrollment are absolutely essential if a sound Red Cross nursing service is to be built up.



Recommendation six encourages the Red Cross to make provision for the post-graduate training of nurses for public health work and for administrative positions in hospitals and training schools for nurses, where no such facilities already exist. There are few Red Cross Societies which have undertaken this type of educational work, but with the development of their schools of nursing, and the growth of their public health nursing activities, the need for these facilities is coming more and more to be felt by the Red Cross Societies. The International Courses established by the League of Red Cross Societies at Bedford College, London, in conjunction with the College of Nursing, have to some extent met this need, by assisting Red Cross Societies to train a certain number of leaders. A very large number of societies have sent nurses to take these courses, and have given scholarships for this purpose, one hundred and sixty-four nurses from forty countries having completed one or other of them. This, however, does not meet the need which exists in many countries for a large number of public health nurses so necessary to the Red Cross Societies if they are to carry out their work on a high standard.

In Siam, it is the Red Cross which has taken the initiative in instituting a six months' post-graduate course for the training of public health nurses. In Finland, the General Mannerheim's League of Child Welfare, one of the affiliated organisations of the Finnish Red Cross, has undertaken the training of public health nurses, and has established a six months' course. The Italian Red Cross has established two courses, one for public health nurses, covering one year of comprehensive study, following upon two years of general training, and a second course for nurses wishing to qualify for administrative and teaching positions, which follows two years of general training and a year of public health training, thus establishing the principle that in future all nurses holding teaching and administrative positions in the Italian Red Cross nursing

service must have had at least four years' training, including a public health diploma.

The German Red Cross has also established a course for Teachers and Nurse Administrators at the "Werner-schule," Berlin. The Course is post-graduate, and open to Red Cross nurses who have already had six years' experience on the staff of a Red Cross "Mutterhaus". It is interesting to note that in all these instances it is the Red Cross Societies of their respective countries which have taken the initiative.

Recommendations seven and eight refer to the public health programme of the Red Cross and encourage the further development of public health nursing activities, together with its programme for popular health education, the objects of which are in keeping with the peace-time mission of the Red Cross.

The founding of the League of Red Cross Societies in 1919, with its very definite peace-time mission, acted as a great incentive to the Red Cross, which hitherto tended to confine itself to preparation for war and disaster, to undertake public health activities, with the result that of the fifty-one member Societies of the League there are few, if any, which have not included them in some form or other in their programme, and there is probably no branch of public health work which has proved its value more than that of the public health nursing service. While it is generally accepted that the development of a public health programme for a community is the responsibility of the Government, there are certain instances where this responsibility has been placed by the Government in the hands of the Red Cross. An excellent example of this is to be found in Latvia, where the greater part of health education of the country is carried out by the Red Cross, through the forty-two health centres which it has established in all parts of the country. While the accommodation for the centre is provided by the local authorities, the staff and supervision are

under the control of the Red Cross. The centres are staffed by a nurse, or nurse-midwife in the scattered rural areas. All are provided with the standard Red Cross equipment, a model of its kind, and function as general health centres for the community.

A somewhat similar situation is to be found in Czechoslovakia, the Red Cross being practically the only organisation working extensively throughout Slovakia by means of the fifty-two health centres which it has established.

It would scarcely be an exaggeration to say that much of the health work in France was carried out by the three Red Cross Societies or due to their initiative and inspiration. They have organised extensively throughout the country child welfare centres, tuberculosis dispensaries, sanatoria and other institutions, in all of which the French Red Cross nurse is playing an important part.

In Italy the Red Cross has considerable influence, and has large public health nursing services with a staff of one hundred and seventy-seven "assistenti sanitarie" working in forty-four different localities. The Governorship of Rome has placed the supervision of its public health nursing entirely in the hands of the Red Cross, and the same is to be found in a number of towns throughout Italy.

The public health nursing service of the American Red Cross, which has a staff of 757 public health nurses, is known far outside the confines of its own country. Traces of its work are to be found in many European countries, which owe so much of their early work to its inspiration.

There is probably no more useful development in public health nursing undertaken by Red Cross Societies than the establishment of "Outposts". No better example of this is to be found than in Canada. As the name implies, these are usually situated in isolated rural districts, and are not very different in function from the ordinary health centre, except that in most instances there is accommodation for one, two or even three patients who,

being out of reach of medical or nursing care in their homes, are brought to the outposts. At the end of 1927 the Canadian Red Cross had thirty-one of these "Outposts," with a total accommodation of 235 beds, 55 cots, and a staff of 77 public health nurses.

A similar type of "Outpost" has been organised by the Finnish Red Cross along the Finnish-Russian frontier. Three of these are already operating, five are now under construction, and the programme of the Red Cross includes a total of fifteen. They are staffed and supervised by the public health nurses of the General Mannerheim's League of Child Welfare.

Popular health education, by means of home nursing and hygiene classes and popular health lectures, has long been an important activity of almost all Red Cross Societies. It has not always been carried out by nurses, but the well-trained public health nurse who has teaching ability is coming more and more to be recognised as a valuable factor in this work.

It is quite impossible in a paper of this kind, the subject of which is almost limitless, to do more than touch superficially on the various public health nursing activities which form so important a part of the Red Cross programme. The contribution of the Red Cross to the world's health has yet to be written; when it is, the part played by the Red Cross nurse will get the recognition it so richly deserves.

Recommendations nine and ten refer to the economic conditions of the nurse, and legislation governing the profession. Number nine encourages Red Cross Societies, in collaboration with the National Nurses' Associations where they exist, to study the means of improving the status and working conditions of the nurse, namely, hours of duty, holidays, medical treatment, salaries, insurance, and old age pensions. There are still many countries where the economic condition of the nurse is far from satisfactory, and while it is essentially the function of a Nurses' Association to occupy itself with this question, there are countries

where nurses are still weakly organised or where no Nurses' Associations exist at all. Good economic conditions go hand in hand with a high standard of nursing; it is in the interest, therefore, of the Red Cross to study this question so as to ensure a high standard of service.

The tenth and last recommendation invites the Red Cross Societies to urge their respective governments to vote, in those countries where no nursing legislation exists, laws relating to the nursing profession. It is unnecessary to emphasise the importance of this. It is in the interest of the public as well as the nurse, and is, therefore, a responsibility of the Red Cross to throw its whole weight into the balance to secure this reform.

When referring to the above recommendations no attempt has been made to quote the exact text, but rather to interpret the spirit of each. It has been quite impossible in this paper to do more than give a bird's-eye view of the great field of Red Cross nursing, or

do more than touch, far too lightly perhaps, upon each nursing activity.

A careful study of these recommendations drawn up by Red Cross nurses, and presented by them to the XIIIth International Red Cross Conference for the endorsement of their Red Cross Societies and their governments, is surely evidence in itself that Red Cross Societies are aiming at the highest standards, that Red Cross nursing no longer signifies nurses trained by means of short, inadequate courses, but rather nursing in its best professional interpretation, and that a Red Cross nursing service consists of a well-trained, well-disciplined corps of nurses and auxiliaries infused with the ideals of the Red Cross, ready to care for the civil population in the hospitals, health centres and in the homes, and ready at all times to respond to the call of the Red Cross in time of great national need with that devotion and enthusiasm so characteristic of the great institution to which they belong.

## *The Red Cross Nursing Programme*

By Mlle. LUCIE ODIER,

Director of Visiting, Red Cross Nursing Service of Geneva, Switzerland

### II.

Originally the Red Cross, as an institution auxiliary to the army, confined itself to training male ambulance personnel; as early as 1869, however, it became clear that women should also be allowed to care for the wounded. The Third International Red Cross Conference, held at Berlin in the same year, adopted a recommendation to National Red Cross Societies "to provide for the training of nurses," to test their capacity by strict examinations and to train them in time of peace by nursing among the poor.

Thus, from the very beginning the problem was attacked in the proper manner, and the Red Cross nurse was made aware of her two-fold duties, in time of peace and in time of war.

Ever since 1919 the Red Cross Societies have been extending their field by developing their peace activities. That, too, is the reason why the League of Red Cross Societies has been founded. Nursing personnel, however, is as before their chief concern.

Nowadays this personnel has to undergo a far more complete and much longer course of training. Some countries have made the acquiring of a "State diploma" compulsory for the professional nurse, and as a result most of the Red Cross training schools have extended their courses to meet this requirement.

The final agreement between the International Committee and the League, arrived at in 1928, has made possible general co-operation with a

view to raising the professional standard of Red Cross personnel. The International Committee will devote itself to training with a view to war and public disaster, while the League busies itself with technical matters arising out of peace activities.

To prevent any misunderstanding, however, it should be clearly understood that the International Committee has always, first and foremost, combated the idea of war and striven to make the pacific activities of the Red Cross pre-eminent by developing the ideals of universal concord and progress. During the terrible struggle that recently devastated Europe, the International Committee, with headquarters in a small republic whose good fortune it was to remain neutral, never ceased to proclaim the principles of charity and devotion which are at the root of all its work. It is still working for this international understanding when it advocates the training of efficient and devoted personnel in all countries, for all that is learnt with a view to war emergencies is useful in time of peace, and as long as a possibility of war still exists it is absolutely necessary that the Red Cross should be prepared to do its duty as a humanitarian agency.

Let us now turn to the programme of the Red Cross Societies for the training of personnel for war time.

The first thing we notice is that this training varies greatly in different countries, even in the most progressive, but that it generally follows the standard adopted for the training of the professional nurse.

For practical purposes, we can approximately divide the various states into three groups:

1. Large nations, with extensive territories;
2. Nations of moderate size;
3. Small nations, with restricted territories.

Let us first examine the position of the Red Cross in large and well-organised countries.

A strong and independent nation is respected by her neighbours, and if she

is prompted by a more or less peaceable spirit the dangers of war, insofar as she is concerned, are comparatively negligible. The financial resources of these nations being comparatively large, as is also the number of their professional nurses, it is only natural that their Red Cross Societies should form from amongst the most capable of these nurses auxiliary corps which can be mobilised speedily in case of need.

The entire organisation of these auxiliary corps depends on the Red Cross, and the solution of such an intricate problem which may vary greatly according to circumstances, naturally calls for minute preparation. It implies taking nurses away from their usual employment, without emptying the hospitals of their staffs or interfering with the proper working of peace institutions. On the other hand, all unnecessary transport must be avoided, as well as any excess or deficiency in the numbers of those mobilised. The latter should be formed into homogeneous and efficient units; for this reason the special qualifications of every nurse should be known, and she should be assigned to such work as she is best able to perform. While one may make an ideal commander of a unit, another may be a perfect subordinate. One unit may do excellent work in case of an epidemic, another may be better suited for ambulance service in time of war.

In the various countries the Red Cross Societies have laid down different rules for the enlistment and the keeping of registers of available nurses. Some training schools oblige their pupils to join the Red Cross for service in case of war or public calamity for a certain number of years after taking their diplomas. In other countries, nurses enlist voluntarily for any period they choose.

Side by side with the enlistment of professional nurses, the Red Cross Societies provide for the organisation of an efficient auxiliary personnel, to assist the trained nurses in their work. These auxiliaries are employed either in hospitals for work which does not require special knowledge or training,



or outside the hospitals for the preparation of ambulance equipment.

Without adequate equipment the efficiency of even the best units is much diminished, if not paralysed. For this reason National Red Cross Societies must co-operate with the Army Medical Corps to provide for a sufficient issue of equipment, so as to prevent all hindrance of their work.

In order to facilitate this organisation, the International Red Cross Committee has opened at Geneva an "International Institute for the Study of Ambulance Equipment," which collects information received from the various Medical Corps. A permanent exhibition of all the articles now used gives to expert visitors an opportunity of knowing the latest inventions and the most practical apparatus devised.

The International Committee has also extended its patronage to a commission of experts from various countries, which is engaged on the task of standardising ambulance equipment. Should this standardisation be achieved, the international co-operation of Red Cross units would, no doubt, be much facilitated.

Countries of medium size, for political and geographical reasons, are in a less favourable position than big nations. The risk of war is less remote, invasion is possible from various quarters, and the invader may occupy a vital part of the national territory. Their financial resources, too, are smaller, and the number of their professional nurses, sufficient in time of peace, is quite inadequate to meet war-time emergencies.

The Red Cross is thus faced with a totally different situation. Although the professional nurse or the Red Cross nurse with equivalent training, must needs remain its first and most important element, the Red Cross should nevertheless provide for voluntary aid detachments, also able to help care for the sick and wounded.

With a view to training this personnel, the Red Cross Societies in better organised countries have founded special schools which give different

degrees of training. Generally speaking, they include elementary, middle and higher courses, the theoretical and practical basis being the same for all pupils. At the end of every course there is an examination, conferring a certificate and giving access to the next course in order. The highest certificate is equivalent to the government diploma, and consequently to that of a professional nurse.

In time of peace or of public calamity, these auxiliaries work either in detachments specially formed by the Red Cross, or they may be placed at the disposal of the Army Medical Corps.

The situation of small states with limited territory, surrounded by larger nations, is even more uncertain, their geographical and political position exposing them freely to armed invasion. Such invasion, with all the suffering it entails for the civil population, may easily cover the whole of their territory. As their population is small, they can call upon only a very limited number of professional nurses—a number which may be sufficient in time of peace but is absurdly inadequate in time of war; moreover, their financial resources are generally very limited. In their case war means the mobilisation of practically the whole able-bodied population.

In these countries, the Red Cross Societies have not only founded training schools for professional nurses, but they have also started to train aid detachments in large numbers. They have organised evening courses and other short courses, where young women of all classes and education may, in a short time, be given some elementary ideas about nursing the sick and the wounded.

If well led and placed under the orders of doctors interested in their training, and of head nurses, these aid detachments, called "Samaritans" in some countries, are able to do valuable service. If, however, co-operation of this kind is to be made effective and produce the best possible results, this personnel must be subjected to strict discipline, and the nurses in charge

must be gifted with considerable organising ability.

The Red Cross must therefore carefully supervise the elementary courses in first aid to the sick and wounded, or better still it should itself organise all such instruction. It should try to interest the medical profession in this work, because the local doctors will of course be called upon to teach the classes. The Red Cross should draw up the theoretical and practical programme of the courses and supervise the carrying of it into effect. These aid detachments, "Samaritans," or whatever may be their official name, cannot in any case be put on the same footing as professional nurses. They will be trained in peace activities, in dispensaries, and so on, under professional supervision. Frequent exercises or competitions between the units will keep them in good training and well in hand.

In these smaller countries the Red Cross should have a certain right of control in the training of professional nurses so as to raise the average standard as high as possible. It is most necessary to find well-educated young girls willing to follow the whole course of training, even if they do not wish to take up nursing as a career, so that in an emergency it may be possible to select the leaders of whom the small countries stand in great need.

The Red Cross should also co-operate with the Army Medical Corps in providing for the complex organisation and the speedy mobilisation of all these volunteers, thus allowing each to the utmost of her ability, to give timely service to her country.

This brief summary has made no mention of the difference between voluntary and paid nurses, because, to our mind, this distinction is not as important as it is too often thought to be. In some countries it is considered proper to pay all nurses who serve their country, while in others Red Cross work is by tradition gratuitous. These two points of view correspond with different national outlooks, and largely depend on the financial resources of the country concerned.

First and foremost, the Red Cross should try to keep its most valuable supporters; for instance, capable and conscientious nurses who have no private means and therefore cannot work for nothing; it should also avoid discouraging girls of the wealthier class from joining the National Red Cross, for they are one of its most important and vital elements. They consider it an honour to serve the Red Cross without payment; and in their willingness to do even menial work they remain true to the spirit of self-sacrifice which is the underlying principle of the Geneva Convention.

In some countries Red Cross detachments mobilised in time of war or of national disaster, without being actually paid, are boarded and lodged at the expense of the army or of the National Red Cross Society. This method has the advantage of allowing professionals and volunteers of all classes to serve the Red Cross, while upholding the peculiarly generous and altruistic traditions of this service.

In 1869 the International Red Cross Conference at Berlin further examined the question of insuring the ambulance personnel and adopted the following resolution:

"A pension should be granted to all persons who have become incapable of earning their living while engaged in nursing the wounded in war, as well as to the relatives of those who have died in similar circumstances."

In view of the ever-increasing risks to which ambulance staffs are exposed in war-time, it is doubtful if many National Red Cross Societies can face the cost of insuring their personnel out of their own funds. An understanding on this very important question should certainly be arrived at between governments, the Red Cross Societies and the Associations of Nurses.

We have confined ourselves to a summary of what the Red Cross Societies in the more progressive countries are doing as regards the training of their ambulance personnel. It should be remembered, however, that all countries do not enjoy the

same degree of organisation. In some of them the Red Cross is not very important, in others it can scarcely be said to exist. There still remains, therefore, a great deal to do in helping these countries to organise Red Cross Societies and to make them familiar with Red Cross principles, as well as with those of civilisation in general.

On the other hand, the International Red Cross Committee has no right to interfere in matters which concern only the National Societies; on the contrary, it is most careful to respect their independence and their liberty of action. Nevertheless, it considers itself bound to encourage any attempt to improve the nursing of the sick and wounded. This is why the Committee has always taken a special interest in the training of an efficient ambulance personnel, and has tried to secure as high a standard of instructors of nurses as possible.

At the Thirteenth International Red Cross Conference, at the Hague in 1928, Madame Chaponniere-Chaix, member of the International Committee, submitted a most interesting paper on the recruiting and the training of Red Cross nurses in thirty different countries. Her conclusions, which were supported by Mrs. Carter, chief of the Nursing Division of the League, led to the adoption by the Conference of ten resolutions, the object of which is to lend new impetus to the development of schools of nursing.

It is in a spirit of world-wide sympathy that the International Red Cross Committee seeks to extend its fundamental principles of progress, self-sacrifice and mutual help to all countries. May your present Conference contribute largely to the international understanding which it seeks, to the progress it desires, to the peace for which it hopes.

## PRIVATE DUTY SECTION

Two meetings of this Section were held with an exceedingly large attendance at each. The Status and Problems of the Private Duty Nurse were presented by a representative from each of the five continents.

This branch presents many problems in South Africa due to climatic, geographic and linguistic difficulties. Thirty years ago, there were few nurses available for private work, and less demand. Now, Miss A. S. Gordon stated, conditions of work have greatly improved, and fees range from \$20 to \$35 per week all over the Union and Rhodesia. Nevertheless, she said, nurses are liable to be sent four hundred miles or more into the native territories, into river diggings or to lonely farms, where water and sanitation are lacking. These cases try a nurse's skill, power of endurance and resources very highly.

Private duty nursing in South African cities differs from elsewhere due to the working classes having more money and demanding private nurses instead of free hospital care.

Miss Gordon emphasised the great need of bi-lingual district nurses who are fully qualified in general and midwifery nursing.

\* In Miss Agnes Chan's paper, she pictured China as a country where this phase of the profession was quite undeveloped. In large cities there are graduate nurses in private practice who have a mutual agreement in regard to fees and working hours, but for practical purposes private nursing has not yet started. Though China can contribute something to civilisation of a character which has its roots in its wonderful history, in matters of health and hygiene she is far behind. Mission hospitals and Chinese practitioners of "Western Medicine" touch only the fringe of the people. The only widespread measure of hygiene is vaccination against smallpox. At every turn, mediaeval medicine, inbred prejudices, conditions of housing, form a barrier against "nursing".

The problem is not just to create large numbers of nurses. On that side, the Nurses' Association of China has already made a great beginning. It is to obtain an adequate medical profession, improved housing conditions, and a great increase in knowledge among the people themselves.

Miss Jessie Bicknell, of New Zealand, described the highly-organised private duty section of her country. In a great many of the towns are residential clubs for state-registered nurses, all of which, with the exception of Auckland and Wellington, being privately owned by experienced nurses. In those two cities, however, they are run by the Trained Nurses Association, and only those belonging to the Association can live there.

Owing to domestic problems, this branch of nursing is most strenuous and each year calls fewer to its ranks. Fees for cases vary from \$20 to \$25 a week, alcoholic and infectious cases being the most costly.

Another aspect of this work is the visiting nurse. She receives her calls from the medical practitioner or through a nurses' club. Her fees vary according to the work undertaken. She fills a great need in the community.

Miss E. C. Kaltoft, of Denmark, in discussing this subject, mentioned that forty years ago, private nursing was done by women with very little or no learning. Now nursing in private homes is mostly done by nurses with three to four years' hospital training.

The registries in Denmark employ only members of the Danish Council of Nurses. Each registry employs a nurse for hourly nursing; this nurse receives her fixed salary from the registry, and also assists with office work.

The Danish Council of Nurses has made provision in various ways for illness, disablement and old age of its members. Miss Kaltoft said in closing: "I do not believe private-duty nursing ought to be a life's work, as when a nurse is no longer quite young



it is not always so easy to get the right cases for her, although many people prefer a middle-aged nurse to a younger on account of her experience, but in general I feel people prefer young nurses."

In discussing Private Duty Nursing in the United States, Miss Janet Geister outlined briefly the growth of nursing. After stressing the need for reorganisation, the speaker dealt with supply and demand, low income, lack of opportunities for advancement, and the irregularity and isolation of the nurse's life. Miss Geister also dealt with the employment of graduate nurses in hospitals and the responsibilities of the Nurses' Registries. In reference to the latter, she said:

"Another significant and hopeful sign is the attention that is being concentrated on our Nurses' Registries. The individualistic method of work of the private duty nurse permits of no combined action in changing methods, in grading the service and in developing new fields. With a few outstanding exceptions, as stated previously, our registries operate only as employment bureaus. They do not function as co-operative enterprises for the advancement of both nurse's and community interest. The registries that are under nurse control have devised rules of conduct and fee schedules which rightly offer protection to the patient. They have not, as a rule, however, devised similar schemes for the protection of the nurse.

"The nurse desiring to do private duty nursing, enrolls on the registry of her choice, paying the fee that that particular registry has established. The registry, in return, when it receives a call for a nurse from hospital, physician or patient, assigns her to answer the call. There are a number of forms of registries. Sometimes the hospital where the nurse received her training maintains a list of its graduates who are called when nurses are needed. Sometimes this is done by her Alumnae Association. Again, the registry may be a Physician and Nurses' Exchange, operated by physi-

cians. There are a large number of registries organised chiefly for money profit by business interests. These are called commercial registries. They represent a very real problem to the nursing profession, for too often, in their zeal for profits, no regard is given to nursing standards. They have grown to considerable strength because the nursing profession has heretofore not placed sufficient emphasis on registry development.

"The form of nurses' registry, which has the approval of the profession is the 'Nurses' Official Registry', organised and maintained by district branches of the State Associations of Graduate Nurses. It is to these we are looking for aid in the solution of some of our major private duty problems. So important do we believe the registry to be that a study of registries with a view to developing minimum standards is the major field work project of the staff of the American Nurses' Association for this year.

"Our present individualistic method of work promotes isolation and unevenness in the standard of work offered. It precludes opportunities for developing new fields, for levelling inequalities, for advancing nursing standards. Organised effort must replace individualism. The registry we believe is the medium for this organised effort. Time does not permit a detailed discussion of the methods by which the registry may substitute orderly organisation for chaotic individualism.

"Briefly, the development seems to be away from the function of a simple employment bureau toward the function of a community nursing bureau.

"Common experience indicates that there are many patients sick in their homes, who would profit by skilled nursing care, but who are not so sick as to require continuous nursing care. Most of these patients for diverse reasons cannot employ full-time nursing service. Our practice has been to ignore the needs of this class of patients. The one partial exception has been the appointment of hourly service offered by the Visiting Nurse

Associations. Even though these organisations are generally adding hourly service on a pay basis to their other activities, they still do not reach the great mass of middle-class people whose minor illnesses are now un-nursed.

"We look to the registry to take leadership in developing nursing service proportionate in amount to the needs of the cases. If the official nurses' registries do not develop part-time service, there is danger that alert commercial interests may seize the opportunity, thereby exposing this new field to unevenness in quality and to inferior working conditions for the nurses. The wide development of hourly nursing service under registry or Visiting Nurse auspices, will result in increased use of nursing service by the public, and therefore, in the employment of more nurses than can find work under our present conditions.

"The registry controlled by nurses will be in a position to protect the interests of the nurse in a way that no individual or commercial group could or would do. In every way the registry is the most logical and powerful

medium for the advancement of nursing interests, and the advancement of nursing standards. The possibilities of registry influence are only dimly conceived at the present time. It is not too optimistic to predict that the registry will gradually evolve into a strong co-operative organisation, touching all phases of nursing work, providing highly skilled, standardised service to all classes of the community in terms of their nursing needs, and assuring the nurse employment and income stability which is now unattainable by her.

"As we look back over the 56 years that have elapsed since our first nurse graduated, we can take hope in the tremendous vigour of our growth. Though this growth has been uneven, the very alertness of our present inquiry into its trends indicates health. Decadence does not begin until growth and inquiry cease. As one nurse has said in a British Nursing Journal, 'The greatest disloyalty we can show our pioneers is not to move one inch from where they stood'. We are moving, steadily, energetically and purposefully toward an ever-improving service for both patient and nurse."

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Miss Isabel Macdonald, Secretary, Royal British Nurses' Association, dealt with Modern Developments in Private Nursing. This paper slightly abridged follows:

"The evolution of the private nurse from the obedient and undiscerning handmaiden to the skilled and discriminating assistant of the patient's medical attendant has been inevitable, for with the development of medical and surgical science the medical practitioner relies to a greatly increased extent upon her knowledge, initiative and resource.

"The patient also is wise to place his confidence in her, realising that she can be relied upon to cope efficiently and with self-possession with any emergency which may unexpectedly arise.

"Well-trained private nurses to-day are ready, with intelligent self-reliance,

to assist the medical practitioner and loyally carry out his instructions for the treatment and care of the patient. Moreover, our young nurses of the present day, with their gay courage and brightness, are adepts in the art of suggestion, and thereby produce effects, better than medicine, on the physical body. Knowingly or otherwise, they have a wonderful fund of practical knowledge in the field of psychology, gathered, most of it, in the school of experience; and surely this knowledge, which many nurses so absorb that it becomes part of themselves, develops in a certain sense into intuition, and is indeed a modern trait which is now practically a necessity in a nurse at the present time, when people are admittedly less prepared to bear sickness and pain with the stoicism and patience that belonged to days when the wheels of life moved so

much more slowly, and put, in comparison with the present, but a small strain on the nervous system.

"The modern private nurse must be a conversationalist. The most forceful and successful private nurses at the present time are those who have wide interests, for then also are they likely to be large-hearted as well as deft-handed. The days when the nurse who smoothed the fevered brow, or gently laved it with eau-de-cologne was considered an ideal private nurse are long past; she has got to get right inside that head with refreshing news from outside the sick room, and to be ready to drive into the patient's mind some suggestion or some new thought that will break the habit, so characteristic of people at the present day, of letting their minds continually dwell on their symptoms.

"In those early days, three months of hospital training were usually considered sufficient as preparation for the duties of private nursing, and it was thought that nurses without sufficient capacity for hospital work could be relegated to this branch of our profession. Now we know that it requires women of much experience, since for the most part their work is unsupervised; they must be discreet, conscientious, and possess initiative, and each must have personality which makes her acceptable to her patients and a support and comfort in a house of sorrow.

#### THE STANDARD OF NURSING EDUCATION

"The requisite standard of training for nurses in England at the present time is at least three years in a general hospital, or hospitals, approved by the General Nursing Council for England and Wales, and I am aware that this standard is adopted in other countries, but the private nurse, to be thoroughly equipped for her work, needs considerably more preparation. Training in the nursing of sick children, in infectious nursing, in mental nursing, and in midwifery or maternity nursing, is also desirable, and, although few private nurses possess all these qualifications, many possess one or more, and

the ideal, that they should have all, is one to be aimed at, for in the course of their work their services are liable to be called upon in connection with any of these branches.

#### THE PROFESSIONAL POSITION OF THE PRIVATE NURSE

"The modern Registered Nurse is a professional person with a defined position, and a State qualification, and medical practitioners, from loyalty to an associated profession on whose help they are so dependent, and patients or their relatives, for the protection of the sick person, should assure themselves that a nurse holds the State qualification before permitting her to undertake duties requiring knowledge and skill, and before admitting her to the intimacy of their houses.

#### LIVING OUT SYSTEM

"One development of modern private nursing is that more and more are the nurses going out from their clubs, small flats, or their own rooms, to nurse their cases; they become day or night workers like other folk doing a definite stretch of duty. This arrangement is wonderfully popular among the private nurses—it gives a sense of freedom and release that they certainly appear to appreciate in spite of having to turn out into the dark night or to take a journey on many a cold morning.

"It sounds paradoxical to indicate, as a modern development of private nursing, the scarcity of surgical cases. Only comparatively rarely now does a nurse go to an operation in a private house, and take over full charge of the case from start to finish.

"In another sense private nursing has altered and become more restricted; very few are the chronic cases that fall to private nurses at the present time; this is largely due to the fact that the nurses' fees have been much increased of late years, and only people whose means are considerable can go on paying indefinitely perhaps four guineas weekly for a nurse, or six if she has to sleep away from her case. But a factor which has influenced this scarcity of chronic cases is the entrance of V.A.D.'s (Members of Voluntary Aid

Detachments) in such large numbers into the field of private nursing work since the War. Many of those are employed by doctors, particularly in the provinces, and there is no doubt that they enter into serious competition with fully-qualified nurses, especially as most of them are prepared to charge a much smaller fee for their services.

"Of recent years nurses have from time to time, and with a varying amount of success, tried to establish themselves in visiting nursing practice, but here again they have to contend with competition from the partly trained. What was once part of the visiting nurse's practice, namely, massage and electrical treatment, has been absorbed into the Red Cross Centres to a considerable extent, while many other V.A.D.'s have taken special training in this branch of work and are visiting the patients in their own homes.

#### THE ECONOMIC POSITION

"Private Nursing is one of the few branches in which a nurse can build up a practice of her own, whether in connection with a co-operation, which is the wisest course, or individual.

"In the development of any business the competitors who will be encountered must be taken into consideration, and those of the private nurse are many and powerful, threatening indeed to crush her out of existence.

"In the first place, many hospitals have now private nursing staffs attached, which are able to undercut the independent private nurse, firstly by charging a lower fee than one which is an economic wage, and further because their nurses, between their cases, can be housed in the nurses' homes attached to the hospitals which are built and maintained by private benevolence. What is more serious is that the committees of these hospitals are able to secure the support of members of the present and past medical staffs, thus restricting the legitimate sources from which independent private nurses would otherwise draw their clientele of doctors. Add to this the facts that many hospitals are opening wards for

paying patients, thus decreasing the number of patients nursed in their own homes, that many doctors now send their patients into nursing homes, that a considerable number of massage and chronic and other lengthy cases are absorbed, as before mentioned, by V.A.D.'s, and that Registered Nurses in private practice have to compete in the open market with the unregistered, and it is obvious that the position of the private nurse is serious. Also, the nursing increasingly provided by insurance societies as part of the benefit contracted for by their clients, must be taken into consideration, although this may perhaps be regarded as a new opening for nurses, provided that these societies undertake only to supply Registered Nurses.

"It will be realised, therefore, that private nursing in Great Britain is still entirely unorganised, and that the competitors of the nurses—including powerful voluntary hospitals—are formidable indeed; it is a very difficult matter to maintain organisations of private nurses and it is essential, if they are to maintain their position in this, and indeed in any country, that the nurses shall co-operate and combine in order to organise effectively.

"I beg to submit for your consideration and discussion the following points:—

"1. What shall be the standard of practical knowledge for a nurse in private practice?

"2. What should be her minimum fee?

"3. Is it advisable for the hospitals with training schools attached to maintain staffs of private nurses?

"4. Is it advisable for National Red Cross Organisations to encourage short terms of training for their nursing members, and to employ such pupils in competition with Registered Nurses?"

In presenting the subject, "The Economics of Nursing," Miss Elizabeth Fox, National Director, Public Health Nursing Service, American National Red Cross, dealt with the nursing system in the United States and discussed at length the supply and demand, the economic factors involved, as the cost



of sickness and the purchasing power of the people, and the need, after which she presented some conclusions which are published in full:

"1. That we shall always need a supply of private nurses for critical illnesses, medical, surgical, obstetrical and psychiatric.

"2. That this need, strictly speaking, is probably much smaller than we are accustomed to think.

"3. That to meet this need we do not require as large a body of private nurses as we now have.

"4. That private nursing is a luxury within the reach of possibly only about ten or fifteen per cent of the people.

"5. That, notwithstanding, critical illnesses occur among the 85 or 90 per cent who cannot afford a private nurse, as well as among the 10 or 15 per cent who can.

"6. That since private nurses are making only a bare living, they not only cannot reduce fees for the families who need them though unable to afford them, but are in need themselves of being assured a more stable and adequate salary.

"7. Therefore, that some other way must be found to furnish private nursing in accordance with the patient's need rather than his income.

"8. That, on the other hand, families are often straining resources disastrously to provide nurses for patients who could be served satisfactorily by the group nurse or student nurse in the hospital, or by the hourly or visiting nurse. These families are straining after a luxury which they do not need, cannot afford, and which private nurses should not be expected to provide at a loss. This presents a psychological problem calling for the re-education of the public.

"9. That the present individualistic system of private nursing is working both to the grave disadvantage of the sick because of the great inequalities in distribution and the high cost, and also to the equally grave disadvantage of the private nurse herself, who must assume all the risk of an unregulated

and uncertain demand and of equally unregulated competition.

"Concerning hourly nursing and visiting nursing, we conclude:

"1. That the greater part of the load of nursing care in the homes must be borne by the hourly and visiting nurses, since (a) in a considerable proportion of cases part-time service is all that is needed, and since (b) the great majority cannot afford private nursing.

"2. That the total number of hourly and visiting nurses at present is not nearly sufficient to carry such a load.

"3. That expansion of hourly nursing facilities to the maximum does not represent a serious economic problem, since when properly organised it would presumably be self-supporting.

"4. That hourly nursing, both to meet the need effectively and to be self-supporting, must be organised as a community service.

"5. That, since visiting nursing is already organised as a community service, and since the difference between hourly and visiting nursing should surely not be one of quality, and probably not of content, but merely of administrative detail, these two could very well be combined.

"Concerning practical nursing, we conclude:

"1. That there is a real need for a secondary worker, primarily to run the household and wait on the patient, but also able to give simple nursing care.

"2. That while the present wholly unregulated practice of the practical nurse permits her to assume responsibilities which can only be undertaken safely by a highly-trained nurse, it does not require even the minimum equipment sufficient to qualify her as a secondary worker.

"3. That the present disorganised state of private nursing is largely responsible for the growth of practical nursing, and especially for its infiltration into areas of service which properly require the knowledge and skill of the graduate nurse.

"4. That the effort to secure or enforce controlling legislation is therefore more or less futile until the profession itself begins to organise to meet the need more adequately.

"5. That satisfactory standardisation and regulation of this secondary service may well come about as the logical result of a better adjustment of professional nursing to the economic situation.

"Concerning the care of the sick by the family, we conclude:—

"1. That there is a considerable amount of sickness of a disabling but quite minor character which can be nursed satisfactorily by the family with some knowledge of sick room procedure.

"2. That the work of the visiting nurse would be greatly facilitated if some member of the family had some previous instruction in home nursing.

"3. That there are large areas of the country where there are as yet no private, hourly or visiting nurses and where the whole responsibility must be carried by the family.

"4. That wide extension of classes in home nursing for women and girls would go far toward meeting these needs and would be an invaluable contribution to the whole problem.

"And finally, with regard to prevention, we conclude:—

"1. That the surest, most effective, most practical way to avoid the bankruptcy of sickness is to keep well. The conservation of health is no fad; it is a grave necessity. The great majority of us absolutely cannot afford to be sick. Whatever else happens we must keep our health.

"2. That this basic fact has not yet registered sharply enough to affect our procedure. Our whole system—governmental, professional and personal—is designed to provide the ambulance at the foot of the precipice rather than the fence at the top, in spite of the fact that the ambulance costs many times more than the fence.

"3. That the present development of public health nursing is far from adequate in scope or extent.

"4. That the nursing profession as a whole is burying one of its greatest talents in the ground by failing to utilise the opportunities which are abundant in all forms of nursing service, as well as in public health nursing for health teaching and health conservation.

"5. That a more adequate development of public health nursing and the universal teaching of health practices by all nurses would tend to change the whole picture, so great would be the reduction in the amount and severity of disease.

### A WAY OUT

"How are these things to be accomplished? That nursing must substitute collectivism for individualism is the tentative answer one hears more and more generally among the profession in the United States today. Organisation, the foundation of success in so many other dilemmas, seems to offer the most helpful method of adjustment. Whether it comes about through slow and cautious steps or through bolder measures, it seems inevitable that it must come eventually.

"Three major developments seem imperative:—

"1. The development of public health nursing to a point where adequate service is given throughout the country.

"2. The education of all nurses to be health teachers, and their acceptance of the opportunities for health teaching in all forms of nursing service.

"3. The devising of a new system of furnishing nursing care for the sick which will provide the essential care, whether private nursing on the individual or group basis, visiting nursing at hourly rates or at cost, or practical nursing, according to the individual patient's need rather than his ability to pay.

"Assuming that no system less comprehensive than this can bring about even reasonably complete adjustment of the profession of nursing to the economic need, how can such

a system be put into effect? Who knows with any certainty? And how can we know until we make a beginning and learn from experience how to go on.

"It seems reasonably probable, however, that any system approaching adequacy, to be economically sound must:

"1. Organise the provision of nursing care for the sick as a public service co-ordinated under one central body.

"2. Maintain a staff of graduate nurses and secondary workers sufficient to meet the needs for full-time and part-time, skilled and unskilled service.

"3. Assure this personnel a reasonable and regular income.

"4. Maintain a flexible system and programme allowing for the broadest and most elastic use of the personnel both in the interests of economy and because of the stimulating effect on the personnel.

"5. Secure the necessary funds to meet unavoidable deficits from the community through taxes, endowments and contributions.

"6. Conduct the entire undertaking according to the most enlightened economic, social and professional standards.

"It also seems reasonably clear that the burden of organising and

maintaining so comprehensive a public service can only be assumed by the community itself through a responsible board representing the general public, the consumer, the taxpayer, the donor, chosen because of their public spirit, their enlightenment, their farsightedness and sound judgment.

"The problems involved in bringing to pass such an unprecedented organisation of a profession are complicated in the extreme. We do not presume to know how all these problems should be met, nor do we believe any one else knows. Experience alone will disclose the solution of many problems. We must not wait until we can see the final goal in detail; we must take those steps we can plainly see just ahead, hoping that they will lead us to other steps now only dimly glimpsed.

"We are dreaming of a miracle in social engineering which some of us believe can actually be brought to pass. We are thrilled with a sense of high adventure and ardently hope to live long enough to take part in this great undertaking and to see it through."

These papers by Miss Macdonald and Miss Fox provoked lively discussion, creating an interest which should result in some thinking among nurses.

At the close of the Congress of the International Council of Nurses, on the authority of the first vice-president of the Canadian Nurses Association, an informal conference of representatives from each province of the Dominion was held.

The purpose of the meeting was to express on behalf of the nurses of Canada the feeling of pride and satisfaction in the splendid arrangements that were carried out in connection with the Congress of the International Council of Nurses, and to express their indebtedness to Miss M. F. Hersey and all members of the arrangements committee and to the individual nurses of Montreal who represented the Canadian Nurses.

[Editor's Note: This note of thanks was published in Montreal daily papers on Tuesday, July 16th, 1929.]

The thanks of the Canadian nurses is also offered to the nurses of Quebec City, who met each boat on which were nurses from overseas en route to Montreal, and to whom hospitality was extended during the stopover in Quebec.

Following the Congress numbers of nurses visited cities in the United States and Canada where they wished to spend several days in making observation and study in one or another of the fields in nursing. The local nurses in those centres made arrangements for these visits and also for the entertainment of the visitors.

### Examinations for Registration of Nurses in Nova Scotia

are to take place Wednesday and Thursday, 16th and 17th October, 1929. Candidates are required to send in their application forms, accompanied by initial registration fee of \$10.00 and diploma before September 15th, 1929.

**L. F. FRASER, Registrar,**  
The Registered Nurses Association  
of Nova Scotia,  
Room 10, Eastern Trust Building,  
HALIFAX, N.S.

### ANNOUNCEMENTS

The annual meeting of the New Brunswick Association of Registered Nurses will be held in Saint John, September 17th and 18th, 1929.

A joint meeting of the Manitoba Registered Nurses, Hospital and Medical Associations will be held in Winnipeg, September 9th to 13th, 1929.

Owing to this issue being devoted to the Congress no News Notes are published.

A limited number of extra copies of this issue are available and may be procured at fifty cents a copy as long as the supply lasts.

**WANTED**—Registered Nurses for general duty in two hundred and fifty bed Tuberculosis Sanatorium. Salary seventy-five dollars per month, with full maintenance. For further particulars apply to: M. L. Buchanan, Matron, Laurentian Sanatorium, St. Agathe des Monts, P.Q.

**NURSES**—Floor Duty nurse wanted at the University Hospital, Ann Arbor, Michigan. Salary \$90 per month with full maintenance. Applicants must be eligible for registration in Michigan. For further information write Director of Nursing, stating qualifications and experience.

**WANTED**—Superintendent wanted for Queen Victoria Hospital and Training School, Yorkton, Sask.; capacity 65 beds and 20 probationers. Apply, giving salary expected, standing, experience, place of graduation and submitting testimonials or references to Secretary, J. M. Clark, Box 430, Yorkton, Sask. Applications will be considered on September 4, 1929.



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# The Canadian Nurse

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### CONTENTS

PAGE

THE CITIZEN IN RELATION TO THE PUBLIC HEALTH PROGRAMME - - - - -	<i>Helen R. Y. Reid</i>	597
EDITORIAL - - - - -		604
CARE OF THE PREMATURE INFANT - - - - -	<i>Edgeworth Murray</i>	605
CHILD DEVELOPMENT - - - - -	<i>Dr. Bird T. Baldwin</i>	607
THE CALL OF ETERNAL YOUTH - - - - -	<i>Mabel E. Finch</i>	613
REDUCTION IN CANCER MORTALITY - - - - -		616
DEPARTMENT OF PRIVATE DUTY NURSING:		
CONSTIPATION: ITS CAUSE AND CORRECTION - - - - -	<i>Dr. N. A. Page</i>	618
DEPARTMENT OF PUBLIC HEALTH NURSING:		
CO-RELATING HEALTH EDUCATION IN A CITY SECONDARY SCHOOL - - - - -	<i>K. E. Dowler</i>	624
THE SCHOOL TEACHER'S HEALTH - - - - -		626
A TRUE STORY - - - - -	<i>Contributed</i>	628
BOOK REVIEWS - - - - -		630
NEWS NOTES - - - - -		631
OFFICIAL DIRECTORY - - - - -		637

# The Citizen in Relation to the Public Health Programme

By HELEN R. Y. REID, LL.D., B.A., Montreal

The citizen's contribution may be in the form of active participation in some of the local or national nursing services, mental or social hygiene councils, child welfare centres and guidance clinics, in parent-teacher groups, health, education and recreation associations, work for crippled children, occupational therapy, fresh air camps and the like. As presidents, board directors and committee members their duties are manifold. These include not only the raising and administering of funds, but also representing the organisation and interpreting to the subscribing public its functions and the part it plays in the larger health programmes of the community. We also find men and women of vision and courage demonstrating the need of new health-giving measures and under professional direction establishing and carrying on such work. In addition, the volunteer is frequently doing specific supplementary duties, such as clerical and motor service, writing reports, speaking, interviewing, etc. This active participation by the volunteer citizen discloses the importance of the definition of relationships between him and his professional partners if the work undertaken is not to be hampered by mistakes due to over-zeal, indifference, ignorance or lack of co-operation. Possibly the time necessarily spent in the past on building up the technique of professional standardisation, procedures and routine, in adjusting relations between the various nursing and medical professions, might now be spent, in part at least, in developing

the technique of working with volunteer committees and with the official representatives of public health in the community. Active participation also develops the sense of partnership, of team play, which goes so far towards the realisation of a true community consciousness, the desired aim and end of all organised community work.

The citizen may also make another contribution to the health programme of the community—that of personal hygiene. Sir George Newman tells us "There can be no public health apart from individual health. This cannot be conferred or imposed by the state. It must be a matter of individual achievement, though the individual may be helped and taught by the state." The wide dissemination of health information, inclined to be propagandist rather than educational in presentation, and sometimes unbalanced and ill-informed, causes a certain degree of confusion in the citizen's mind. "The things we are advised to do in respect of clothing, diet, etc., are so numerous and varied that we incur some risk of not knowing what course to adopt, what to accept and what to decline, and consequently of doing nothing. Year by year, transmission of such knowledge should be more exact and its application more in accord with the best kind of human experience." Sir George goes on to say that "Personal health is not an accomplishment but a growth—a growth which depends on the nature of the individual, his constitution, and its sound nurture. Nature and nurture lie at the foundation of all true growth, and all true health, and they are mutually inter-

related. We cannot select our parents, nor change essentially our germ plasm or the character and formation of our bodies. This is our inheritance for better or worse. We can, however, study to know and understand our capacities and tendencies, and this is the first step to personal health. We can also ensure to succeeding generations better stock or constitution. Sound mating is the beginning of good breeding—unwise mating is a source of enfeebled health, of unstable disposition or even of disease. It is also possible that individual immunity and the chemical constituents of the body may be transmitted from parent to child.” The citizen should consider more seriously these latent forces of heredity which have probably as much to do with personal health as any other factor. It is still more futile to neglect the proper nurture of the body. The body is not a machine but a growing organism with its own individual tendencies, idiosyncrasies and susceptibilities. Age, sex and circumstances should govern methods of personal hygiene. What is now common knowledge about food, fresh air, exercise, warmth and rest should become common practice—the daily practice of the physiology of the body, not only that it may perform its daily work, but be able to withstand the strains and infections to which it will inevitably be subjected.

If the citizen wants to be well and to keep well, let him ask his hospital or physician for periodic physical examination. By creating a demand for such examination the citizen will hasten the day when the rank and file medical practitioner will in turn demand university training for the promotion of health as well as for the cure and treatment of those who are ill. May not the citizen seek, too, a quickened enthusiasm with regard to personal health, and cultivate for our young people admiration for strong, enduring, robust types who have done and are doing great things in human history?

Again, the citizen who is neither poor enough nor rich enough to obtain adequate medical and nursing care may hope that the socialisation of the medical and nursing profession, partly through field observation in the home, will precede the dawning of the day of state health insurance where this does not yet exist, so that exorbitant and impossible demands on individual and domestic resources will not be made by highly trained professionals unfamiliar with the conditions under which their patients live.

If he is active in health work, the citizen will realise that public health officials and health experts are human beings and citizens like himself. Doctors, nurses, public health officials and other awe-inspiring health authorities do not fulfil their duties as citizens if they forget in their busy, generous days what the ultimate aim of their service is, namely, not only the cure of the individual but the sharing with him the newer responsibility of preventing disease and of promoting the health of the entire community.

#### PROBLEM

In the title of the address assigned to me we may find, if we will, an age-old problem, which is still awaiting solution. This is the problem as to whether the good of the state is a higher good than that of the individual. Is this a conflict between irreconcilable opposites or is it a manifestation of two legitimate ways of living which await interpretation, reconciliation and synthesis?

Public and private or voluntary health organisations exist side by side today in most civilised countries. The citizen may be mystified at what at times appears to be an overlapping of activities, he may therefore be distressed at the apparent waste of time, thought, energy and money, particularly when he is finding it increasingly difficult to pay for medical and nursing care himself, but he must acknowledge that as a result of the organised application, both private and public, of the findings of medical



research, nursing studies and preventive medicine, the life of the ordinary man has been lengthened by many years, and those years have been rendered more free from the terrors of communicable and other dread diseases. The citizen, in the last analysis, bears the burden of illness and pays for all health service. He may therefore reasonably inquire whether the time is not ripe for systematic co-ordination, controlled or voluntary, of all health programmes and for directed co-operation of all health organisations.

All are agreed on the value of health. Our value to the state is incalculably enhanced by a high standard of health. Positive health is, truly, more than freedom from disease. "Positive health," as Professor J. Arthur Thompson tells us, "includes vigour, resisting power, capacity for initiative, clear-headedness and *joie de vivre*."

Any consideration of the present trends of health service must take into account the historical and political developments as well as the environment and conditions of the population in whose countries such health work is being done. No judgment or even an approximate estimate of the value of such service can be rendered unless these larger factors—including variations in conditions in different parts of the same country—are taken into account, for the historical and local setting affect very greatly the character of what is termed the public health programme, as it does that of health work undertaken by the private or voluntary agencies, and the relationship of both of these very definitely, in turn, affects for good or ill the health of the individual and that of the community.

The great undertaking of the doctor and the nurse, of the research worker and the health organisation, be it public or private, is, then, to prolong man's days by reducing premature mortality, to remove the cause of disease and its results, and to enhance

the physical and mental capacity of all classes of people.

Public and voluntary health work exist side by side as an outward expression of this interest, impelling both the state and the citizen group to undertake health work. The progress made in medical science and research into the causes of disease and their cure has made preventive methods general and has set on foot a parallel movement in all countries. Preventive methods, first developed by private organisations, have had great influence on the state, which is now undertaking preventive work partly as an obligation laid down by law and partly as voluntary effort causes the boundary line between public and private health work to become a fluctuating one. Hence, many of the causes of irritation and misunderstanding between the two!

It is symptomatic today that progressively minded governments are going far beyond their legal obligations in the development of preventive work. It is recognised as a law of evolution that efforts originally initiated by private enterprise are taken over by the municipalities as soon as public opinion recognises the need for them. The original agencies, be they for child welfare, public health nursing, tuberculosis or other health work, experience very natural regret at handing over to public authorities work built up through years of painful effort. The private organisation often makes the criticism that the transfer does not always guarantee higher standards of work, improved administration and better service for the individual, and, most important of all, that doctors and nurses who are authorised agents paid by the state or public authority are not filled with the personal devotion to their calling that is supposed to characterise the private agency worker. There may be some truth in this, but possibly it should be a matter for pride rather than discontent on the part of the private agency that its work has been recognised and

thus made available in a much wider and more extended form. We must admit, however, that while the private agency may and does select its clientele, the public organisation, under a legal and publicly organised obligation, has to consider general interests and great numbers of people. This demands much division and subdivision of work, which may easily degenerate into official routine, and renders individual work more difficult. When politics interfere, there are indications at times that the expansion of the public health field is consciously directed against the private agency.

#### FIELD OF PUBLIC HEALTH

It is now an established fact that sanitation, food control, communicable disease control and improved environment are the foundations on which the superstructure of other public health services stand. To local public authorities have been given many statutory duties in respect of sanitation, nuisances, water supply, food control, river polluting, housing, communicable diseases, hospital accommodation and so forth. Following these we have a duty recognised as belonging to the state of ascertaining what the situation is—the notification of births and infectious diseases, the certification of sickness and the registration of death. Here the citizen may give co-operation by helping to make these records adequate and correct. We recognise, too, the state's obligation in the matter of industrial legislation. Factory Acts and workmen's compensation, not primarily of state origin, are now under state control—though here, in this field, we see the voluntary organisation of employers or employed supplementing and sometimes going in advance of government in preventive and constructive health measures. However, it is when we reach the field of maternity and child welfare, of personal hygiene, of the control of special diseases, of research, of demonstration, of all that is included in the word *Nurture*, that we find the latest manifestations of governmental en-

deavour in preventive health work. The question, therefore, follows—should there be a systematic division of service, an effective delimitation of the actual fields of work between the two agents, public and private? If such division is not possible, should there not be co-ordination and co-operation? In either case, who is to take the initiative in instituting the necessary measures? On which agency should this responsibility best fall?

A serious factor to be considered here is the immense number of both kinds of organisation, public and private, collective and independent, in almost every country. We find, as a result, that there is a growing tendency both in Europe and America towards establishing local, national and even international Leagues, Unions or Councils of Health and of Social Welfare. This removes some of the difficulties due to friction and misunderstanding, and makes interpretation and actual inter-relationship with official agencies easier and more effective. In the western world this consolidation of interests of individual agencies comes not from government control but from the recognition of the need by the agencies themselves, a healthy and truly democratic development.

A closer relationship to governmental bodies is often indicated through the subsidising on a service basis of the voluntary organisations by the state, a very general practice in America and one that has both good and bad effects. Hospital service is frequently provided in this way, and so the question is often asked why district nursing service for those who cannot go to hospital, who cannot afford to pay and who are not under a government insurance scheme, should not receive a similar recognition on a per capita per diem cost basis. When the state actually transfers some public health duties to a private organisation, as in the case of Hungary and the Red Cross, systematic financial recognition naturally

follows, with resultant economy to the country, for it is nearly always found that administration and running costs are considerably less in the voluntary organisation.

In the western world the pioneer tradition is still strong. The love of discovery, the eagerness to be doing something, lead the people to welcome change and to share in the change. Decentralisation and individualism, therefore, characterise much of the social welfare undertaken in Canada and the United States. Instead of state health insurance protecting over fourteen million workers in Great Britain and over eighteen million men and women in Germany against illness, and providing for them both cash and medical benefits of various kinds—instead of a controlled partnership between the state and the medical and nursing professions, so distinctive of Germany, Japan, and of Great Britain to a somewhat lesser extent, we have in our western world an astounding number and an extraordinary variety of independent voluntary health organisations attempting in their scope to cover national, provincial or state, as well as local health needs. The surmise has been ventured by an American public health authority that such a development is due, in addition to the qualities of youth referred to a moment ago, to the fact that in the new world the sense of community responsibility is greater in the individual man in the street than it is in those who occupy positions of authority in government—that the civil servants of the best European countries are more trustworthy and efficient than they are in the United States, and that therefore if Americans want enhanced health they must undertake most of the activities and responsibilities towards this end themselves. Be that as it may, the contribution made by voluntary health agencies in America, particularly in the demonstration, survey, research and more especially in nursing fields, is without a parallel in the world's history.

In its new bibliography the Department of Surveys and Exhibits of the Russell Sage Foundation lists no fewer than 2,700 surveys. Those in Health (458) and Education (582) top the list. The Cleveland Health and Hospital Survey is one example of the many outstanding contributions in this field. Two universities and four national health organisations participated in this survey on the invitation of the twenty-one institutions organised in the Cleveland Hospital Council, all those interested being voluntary organisations. Other specialised community health surveys by private organisations have been applied to special divisions of health requirements, such as tuberculosis needs and resources.

Paul U. Kellogg, Editor, *The Survey*, and Dr. Neva R. Deardorff, director, Research Welfare Council, New York City, reporting for "Social Research as applied to Community Progress" at last year's International Conference on Social Work held in Paris, tell us also something of the research work undertaken by the great American foundations, of which 150 were listed in 1926. This great flowering out they attribute to the cross fertilisation of the scientific spirit with social consciousness, and to the rapid advances in personnel and technique, ideology and experimentation. The "fertilisers" themselves also receive their just tribute of praise. With so much effort, time, money, under expert voluntary direction in research in health, the question is raised whether any stultifying effect follows in university and in public health domains. Apparently not, for the statement is made that this kind of citizen interest, this research work fostered by the great foundations, have actually stimulated government activity, both federally and in the states, as is seen in the work of the numerous government health commissions recently appointed. Neither have the universities given up their creative scholarship and research work. They have, instead, be-

come stimulated to undertake new work in new directions. Thus knowledge has been trebly advanced.

One cannot help apprehending the limitation upon freedom of thought and action when great funds and the tremendous power that goes with them are placed in the hands of a small group. Directors are apt to attempt the direction of opinion—the cast of thought rather than the encouragement of thought. Perhaps such directors—be they foundations, university or state governors—should themselves be surveyed and studied in order to see whether with their giant opportunities they are really facing and exploring our giant social problems, or if with directed discretion they are neglecting these for the consideration of problems less urgent and of less importance.

In addition to the voluntary enterprise in surveys, demonstrations and research of the great foundations there are, in the western world, a confusing number of independent health associations. Most of them are doing good work and some of them are connected, loosely, it is true, with other organisations having health, education or welfare work as their objective. If recognised by the state through grants or subsidies, there is little if any attempt on the part of the government to guide or co-ordinate these independent efforts. We cannot be blind to the dangers of gaps left unfilled, of duplication that so often may occur when an individual agency, limited in authority and resources, in outlook and policy, undertakes community health service. The special opportunities of the voluntary agency are, truly, those of pioneering, experimenting, demonstrating and popularising new health measures and higher standards of work. Experience has already taught them some of the advantages of co-operation. Is there not a further step now needed in the direction of systematic co-ordination of the work of all agencies, both public and private, that are doing health

work? With the increasing complexity of civilisation and the tremendous “machineries of existence” which are conditioning the life and labour of all of us, is not such systematic co-ordination of a continuous kind not only desirable, but, every day and every year, becoming more and more necessary?

In Europe, the modern tendency at work demands the intervention of the state because of the recognition of the fact that the social ills they are trying to combat are the results of defects in the whole social and economic order. In that older land there has grown up a feeling of collective responsibility and a recognition of the need for centralised control, intensified since and because of the war to the end that the state, by means of legislation and administration, may act both as guardian and as agent of the welfare of the people. State insurance against ill-health, old age, accident and unemployment makes provision for such hazards as affecting the lives of the citizens.

Organised co-operation with systematic co-ordination of health and welfare work by the state may come about either by legislation or by voluntary agreement. We find it since the war in different stages of development in Holland, Poland, Italy, Sweden, Germany and Japan.

A typical example may be quoted in Germany's legislation of 1924-25 regulating the co-operation of public and private welfare organisations. The Reich law on health insurance provides a basis for the combination of the individual agencies doing insurance work for sickness, disablement and employees' insurance, and for their co-operation with agencies of public and voluntary welfare, primarily those interested in tuberculosis and venereal disease. The local welfare offices are responsible for the conduct of welfare work and have to form a liaison between the public and the voluntary organisations. They aim at getting the public and voluntary



organisations to supplement each other's activities and to collaborate in such a way that each will preserve its own independence. The Reich committee for health propaganda has under its guidance state committees which decide on forms of organisation, local committees which carry on the work of instruction, and district centres for the country districts and small towns. On the Reich committee are representatives of the medical profession, the insurance societies, the Red Cross, and voluntary associations for different branches of health service.

This European example of detailed control and supervision is in striking contrast to the less regulated relationships between western public and private organisations doing welfare work. We are thus brought once again face to face with the problem which is implicit in the title of the address, the apparent opposition of the ideals of independence and co-operation, of the individual as opposed to the collective way of doing things. We are more ready, perhaps, to agree that these ideals are not mutually exclusive, but that they are manifestations expressed in different and largely unrelated ways, of one and the same ideal.

We recognise that historical and environmental factors account in large measure for the diverse developments in health work in different parts of the world and in different parts of one and the same country. In the light of history we can see the gradual emergence from primitive

conditions of all forms of public authority and government, the individual citizen or citizens repeatedly taking the initiative with a courage sometimes born of despair and with truly heroic persistence in instituting reforms for safeguarding the life and well-being of the people. We acknowledge the present-day need for increased division of labour, for specialisation in science, for detailed and accurate research in medicine and public health, but are we not also acquiring more and more the sense of collective responsibility? Do we not feel that team play is needed, and that citizen, doctor, nurse and public health official are all partners in the great adventure of healthy living? We see both forms of health service—public and private, independent and collective—working side by side, at times with friction and without co-operation, at times displaying amazing success or inexplicable failure. We know that both ways have their rewards and both have their dangers. For certain purposes, at certain times, and given certain conditions, the enlightened citizen will recognise that the particular end in view requires independent specialisation of work; and at other times he will see the need for synthesis, for generalisation, for application of the facts to a collective purpose.

"Seeing health needs sanely and seeing them whole" is perhaps, then, the chief contribution, as it is the most difficult, which the citizen can make in relation to the public health programme.

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# Editorial

1908—1929

Twenty-one years ago on October 8th, representatives from sixteen nurses' associations in Canada met in Ottawa and founded the Canadian Nurses Association.

Today we may well pause to pay tribute to those women who accepted the challenge to organise the numerically small group of nurses in the Dominion then active in nursing. Those women recognised the need for some means whereby the members of the profession could be provided with a bond which would unite them nationally: and a national organisation was the logical means. An organisation whose "objects" were (and still are): to encourage mutual understanding and unity among the nurses of Canada; to advance the educational standards of nursing; to maintain the honour and status of the nursing profession; to acquire a knowledge of methods of nursing in every country; to afford facilities for international hospitality and to encourage a spirit of sympathy with the nurses of other countries.

A review of the past years reveals that these aims have been accomplished and it is for us to carry into the future all that is best from those years of our organisation and to value what has been achieved to place us in the fortunate position in which we are today.

To render tribute is not enough. It is for us to "take stock" of what lies immediately ahead. There is much that requires the unity and enthusiasm of each one of us.

Very soon there will be commenced the actual study of nursing as agreed upon by the Canadian Medical As-

sociation and the Canadian Nurses Association. It is recognised that present conditions require this study. It must be kept in mind that the benefits eventually derived shall be in proportion to the interest shown by the individual nurse.

Then there is the troublesome question of "Dual Membership" in the national organisation. The special committee appointed to make a study of this vexatious condition has attempted to interest all associations involved. Now is the opportune time for these associations to express an opinion as to their desire to have present membership continued or to make suggestions in regard to what other plan they wish adopted.

Plans are already in operation for the Biennial Meeting, 1930, which is to be held in Regina, Saskatchewan, while several committees are busily engaged with inquiries affecting Nursing Education and Schools of Nursing.

As associations of nurses re-open for this season's meetings may they remind themselves of their professional obligations: many members of these associations attended the Sixth Congress of the International Council of Nurses, and now possess an enthusiasm born of the wonderful experience which should infuse a new spirit, and develop clearer thinking and vision into those ideals which are our inheritance.

Let our united objective be: the progressive unfolding of a Canadian Nursing Profession and Service—one which shall be a joy to those who belong as well as to those who are served.

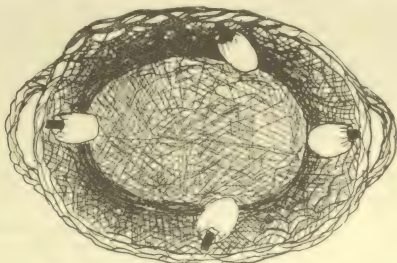
## Care of the Premature Infant

By EDGEWORTH MURRAY, Supervisor, Children's Department, Royal Alexandra Hospital, Edmonton

Premature and very small infants have a large body surface according to their bulk, therefore, the evaporation of body heat is more rapid, and, in order to conserve this, it is necessary to keep them extra warm. The temperature of the environment should be about 80 degrees F.: some authorities say from 70 degrees to 80 degrees, and others from 80 degrees to 90 degrees. This air should be fresh with a humidity of 55 degrees percent, and an air space of about 1,000 cubic feet.

In the modern children's ward scientific methods of structure as well

can be made in the lining to hold glass bottles of hot water; these are left uncorked to supply the necessary moisture in the atmosphere when a blanket is placed over the basket. The water in these bottles is 115 degrees F., and they are changed one at a time in order to prevent the temperature of the infant oscillating, which of course uses up the infant's energy. If the glass bottles are not used, rubber hot water bottles take their place, and the water is the same temperature. Additional moisture will be required then; this may be obtained by putting a pan of water



No. 1—Clothes basket with flannel bags containing bottles for hot water.

as heating apparatus make the problem of uniform warmth with humidity more possible, but where such conveniences are not available methods must be contrived by the nurse to meet these needs. The use of incubators is gradually being discontinued, as they were found complicated and unreliable unless constantly watched—the ventilation in them was usually poor, and the humidity too low.

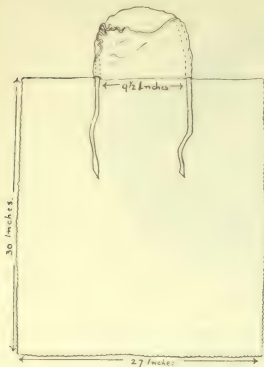
A cheap simple satisfactory bed may be made from a clothes basket 30" long, 22" wide and 18" high (Diagram No. 1), having a padded lining, and using a pillow for a mattress. About six or eight small pockets

on the radiator or by having a small electric stove and steam kettle.

A thermometer is wrapped up in the baby's blankets and this is kept at 80 degrees F. The infant's temperature is most desirable at 99° degrees. Anyone who has cared for premature infants can appreciate the difficulty of maintaining this temperature. Each time his temperature is taken he is turned from side to side and on his back. Only those in attendance on the infant are permitted in the room. The nursery light is of course subdued, and noise is taboo. It is wise to have a No. 10 French catheter on hand with oxygen in case of cyanosis.

No premature or very small infant can stand much handling, as it produces shock. They are cleansed each day or every other day, as the doctor wishes, by using warm olive oil. The nostrils and lips are kept moist with sterile vaseline or olive oil. The nurse's hands and everything that comes in contact with the infant is first warmed. The infant is weighed in his soiled flannel jacket, and then lifted gently into his fresh warm one, exposing as little as possible of his small body. The soiled jacket is then weighed and the correct weight determined.

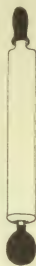
The clothing of the premature infant in former days consisted of a



No. 2—Flannel cape for premature baby.

padded jacket made of absorbent cotton and gauze. This is now replaced by a similar jacket made of flannel 30" long and 27" wide with a hood attached (Diagram No. 2). The absorbent cotton produced too much humidity next the skin, and the danger of the infant catching cold was very great. The cord is dressed with a sterile gauze binder and

surgical technique is carried out as with other infants. Crede's method is used in the care of the eyes. These are later swabbed with boracic solution when the infant is having his oil rub. Cello wipes take the place of diapers, as they can be easily changed and are absorbent. The infant is placed in his flannel jacket, with the hood fitting snugly about his head. The jacket is pinned at the side and folded up over the infant and pinned at the bottom with small safety pins.



No. 3—Breck feeder.

When feeding premature infants the Breck Feeder (Diagram No. 3) is used in preference to the medicine dropper as the latter permits a considerable amount of air to be swallowed. This induces emesis as the air gets back of the milk in the stomach, and in order to expel the flatus the infant has to vomit his food. The Breck Feeder also conserves the body energy, which is no small item. These infants need to be roused and induced to cry as lustily as possible before each feeding by flipping on the brow or cheek with the finger nail. This improves the circulation generally and the infant progresses much more favourably. When prematures commence to gain they do so more rapidly than ordinary normal infants.



## *Child Development*

By BIRD T. BALDWIN, Ph.D.,

Iowa Child Welfare Research Station, State University of Iowa, Iowa City.

(One of a series of lectures delivered in Toronto and Montreal under the auspices of The Canadian National Committee for Mental Hygiene, in collaboration with the Department of University Extension, University of Toronto and McGill University.)

For generations the problem of the influence of heredity and environment on the development of individuals has been of serious concern to scientists and educators. The problem is still a baffling one, on account of the many factors that contribute to heredity and the extreme complexity of environmental influences. Recently we have heard more about nature and nurture, but these are general terms, not easily defined. Personally, I believe I am beginning to focus the problem more definitely and to see a tangible solution. The problem may be stated thus: What is the relation of capacity to training? We are today in a position to determine with a fair degree of accuracy the capacity of a child at any point in his development from six months to sixteen years of age. We can determine his physical status and probable development, his intelligence rating and probable mental growth. After the age of two or three years we can determine certain phases of motor capacity and motor control; the degree of emotional response as indicated by introversion and extroversion; fairly definite patterns of behaviour in the presence of other children and adults: the size of vocabulary and the use of languages. During school age we can diagnose educational capacities and musical ability. In short, we have developed standardised methods of technique and objective criteria for measuring capacity and subsequent training. And, after all, is not this the aim of education, to develop the capacities and abilities of each individual to the maximum? The important factor is the increase in increment of

growth of each individual, based on his initial capacity. Nature furnishes the basis for education, but environment and training are the determining factors in producing the final product.

The personality of a child is a changing, complex, integrated unity. We are just beginning to realise and appreciate the complexity of a child's physical, mental, educational and social make-up. The past decade in education has been one of analysis, and much has been accomplished. Educators and parents are beginning to realise that the essential factor in dealing with a child lies in the unity of his personality. The newer psychology will define the child in terms of objective criteria of behaviour which take into account the combined influences of physical condition, mental development, educational achievement, emotional trends, personality traits, and social attitudes. We are just on the verge of discovering the kind of adult into which a child will probably develop. We can already predict the child's adult physical make-up. With less surety, as yet, we can foretell his adult intellectual capacity. And, in our work with pre-school children, we are discovering early types of emotional and social patterns. We believe that we are finding social reactions among children that give every evidence of being definite forerunners of adult temperamental and social patterns. Please take notice that when I speak of changing temperaments I refer to little children and not to fathers and mothers.

My first interest in child psychology began with the mentally defective, then it centred in adolescence.

But today it is with the pre-school child, for I see the genesis of a majority of problems of adolescence, especially delinquency and social maladjustments, during the ages from one and one-half to six years. These, I believe, are the most important years of childhood.

#### NORMAL CHILD

The extensive work that has been done throughout this country and abroad on defective children during the past decade has helped to clear the ground and to suggest some methods of attack for the fascinating and profitable work on a more basic problem, the so-called normal child. It is, of course, more difficult to see the finer differences among normal children, to note how handicaps and how special defects may be removed and native abilities improved than to observe marked abnormalities among children; but it is decidedly more interesting and more important because with these normal children lies the progress or retrogression of the race. Better children make a better state.

What is a normal child? In a bulletin published by the Federal Bureau of Education in 1914, I stated that the personality of a child is a complex physical and mental unity. For scientific purposes different phases of this personality must be treated more or less independently for analysis, description and explanation, and later synthesized. In the past, scientists have tried to describe an "average child" at a given chronological age, without realising that in so doing the wide individual differences which exist among children destroy or compensate each other. The concept, "average child," is impossible and impractical. A new approach must be formulated which will preserve the integrity of the individual, differentiate special traits, and offer a series of norms or standards for various types from different points of view.

The child's demands are manifold. They are also interdependent; body and mind develop together, while emotional habits and the maturing of the nervous system condition both. Many parents give the child excellent physical care, but take no interest in his intellectual development; others are ambitious for his mental growth, without trying to build a sound physical foundation; still others allow the atmosphere of the home to be strained or unhappy, without realising that the child who thus becomes emotionally unstable cannot develop freely, either mentally, socially or physically.

For purposes of scientific analysis and explanation, every child may be said to have five parallel and inter-related ages: (1) a chronological age in years, months and days, denotive of the temporal span of life; (2) a physiological age, denotive of the stages of physical growth and physical maturity, which is the basic age in growth; (3) a mental age, denotive of the growth of certain mental traits, capacities, interests and abilities; (4) a pedagogical or educational age, denotive of the rate and position in school progress; and (5) a social age and moral age, denotive of the growth of social attitudes and the ability to make, adapt and control social adjustments. These five ages are all present at any chronological age of a child's development. A child may have reached his maximal status in one or more of the four ages, excluding the chronological, and may be retarded in the others. For example, a boy or girl may have normal physical development and be retarded pedagogically, socially or morally, or in any of the other combinations. In a normal child each age is developing at its maximal rate and the physical, mental, educational and social ages nicely balance each other. One need not be neglected as a sacrifice for another.

That the different phases of a child's development are not parallel

with his chronological age can be readily illustrated by a brief analysis of anatomical and physiological growth. We now know, after long study of anthropometric measurements, how children grow in form. We have data that throw light on the relation of anatomical development to physical growth in form. But we need further data on the relation of exercise, diet and environment to anatomical growth. The division of nutrition of the station is working on the important problem of diet in relation to anatomical age and physical growth.

#### SKELETAL GROWTH

As the best index of skeletal growth we early selected the development of the carpal bones of the wrist and formulated a method of measurement of these bones as shown in x-ray pictures, of which we have about 1,300 of children from birth to seventeen years. The wrist ultimately contains eight small bones which ossify at different ages and at different stages of maturity. Each child has his own anatomical time clock, but there is an approximate average; for example, for the boys, two bones are usually present at three months, at two years a third bone is visible, at four another, at five a fifth, at six a sixth and seventh and at eleven years the eighth bone appears. With the exception of the first three the ossification of these eight bones occurs one to two years earlier for girls than for boys. The rate of growth of these bones is parallel with growth in height except that the decrease in increment of growth of carpals occurs earlier in adolescence.

The two bones of the arm, the ulna and radius, the five metacarpal bones of the hand, and the fourteen phalanges, or finger bones, are all in ossified form, as a rule, at birth. Distinct caps of epiphyses appear after birth and later fuse with each bone. The girls are at least two years in advance of the boys in both the appearance and fusion of the

epiphyses. In the x-rays the little epiphyseal caps stand out prominently in little children; at about fifteen years of age they begin to fuse in the fingers and hand, and at sixteen and eighteen in the two bones of the forearm.

The status of the anatomical growth of the child raises another significant and far-reaching problem on which the station has been working for a considerable period, namely, the physiological age of the child. The problem of physiological age is an important phase of the development of normal children which has received little scientific study. Our results based on eastern city boys and girls, boys and girls from Chicago, Iowa City, and California, and eastern country children show a wide distribution for the one set of physiological functions of adolescence. The range is from nine to seventeen years of age for girls and from eleven to eighteen years for boys, with no particular age including more than forty per cent. of the number of children.

Various investigators in their eager efforts to describe children have arbitrarily divided the life of the child into definite periods; our researches show no marked periods, but a continual overlapping and a gradual transition from one period to another. The progressive stages of physiological development cannot be measured quantitatively like height in inches and weight in pounds. Correlations between the stages that are fairly definite and height, weight, width of hips, and circumference of chest of several hundred mentally gifted children indicate that, for the given age, the taller and heavier children are relatively more matured physiologically than the shorter, lighter weight children.

For the mental growth of the child there are certain principles that are fundamental. One is that the child is most likely to think when he has need. A devoted parent sometimes keeps a child dependent, because he does the thinking for the child. During the

first years of childhood, independence and ingenuity may be developed through play materials. For this purpose, home-made toys and blocks are always desirable since they offer children constructive interests that challenge their abilities and perseverance. Little children who have attended pre-school laboratories or nursery schools require much less care and attention in the home, because they have learned how to play with materials and toys adapted to their stages of mental and physical development. They have learned not only to play, but they have acquired something much more important—how to play with other children and how to invent new games or to modify the content and methods of their play activities.

#### PRE-SCHOOL CHILD

It is now generally recognised that the first six years of a child's life determine in a very large measure his future development and usefulness. A child's mind needs to grow and to be trained during this period of early childhood, just as much as his body. Many very important facts and principles on mental hygiene may be gleaned from the literature of child psychology and from books, pamphlets, and magazines on education and mental hygiene.

During recent years, the pre-school age has been the focus of observation and experimental work in education. At Iowa, the pre-school laboratories were established in 1921. We began with children from two to six years of age, and had a fairly simple programme of determining the capacity of individual children for education from the standpoint of intelligence, emotional trends, social attitudes, language habits, learning, motor control, and physical growth.

At present we have four pre-school laboratories similar to the nursery schools at Toronto and McGill. About one hundred children between twenty months and five years attend daily. Some of the little children who started with us seven years ago are now in the fifth grade of the University Ob-

servational School. The purpose of these laboratories is to give the children an opportunity to come into daily and intimate social contact with other children of similar stages of maturity in an environment adapted to child rather than to adult life. Complexity of training, over-stimulation, and pronounced theories of education have been avoided as far as possible. The children come from all classes of city residents; they attend from three to seven hours daily.

From a scientific point of view, our purpose has been to secure suitable material and data for intensive studies of young children, who as a rule are not available for study, under conditions that are so controlled and modifiable that the experiments may be repeated and the children studied consecutively from day to day. The observations and experiments are conducted by members of the staff and graduate students. Members of other divisions and colleges of the university are also carrying out special experiments.

#### PRE-SCHOOL HOME LABORATORY

In our pre-school home laboratory, now in the third year of operation, the children may be from eighteen months to four years; they attend from nine in the morning until three-thirty in the afternoon. This laboratory is designed to be a modern home, based on the best methods of feeding, regular schedules for sleep and play, and training in mental development and child behaviour. A home environment under scientific management offers a new field of investigation in the needs and training of infancy and childhood, especially in the more complicated behaviour problems. The laboratory is in a house of eighteen rooms and a large sleeping porch, with ample grounds and gardens. Here are also located the baby examining laboratory and offices of the child study and parent education division of the station. The aim is to integrate as many sciences as possible from the various departments of the university and to study the child as



a unit; that is, from many angles rather than from a few.

The social adjustments of the child are too liable to be determined only by adults and their activities. With the young child, as I have emphasized on other occasions, personal-control habits of eating, drinking, dressing, sleeping, cleanliness, elimination, and the right attitudes toward regularity are very important from the adult point of view, but are not adequate for the child's development. The basic aim of education should be to furnish a simple but enriched environment adapted to the child's stages of physical and mental growth—an environment in which he can find himself in relation to other children and adults; an environment in which he can develop through daily participation such important personality traits as independence, self-direction, self-control, constructive imagination, creative self-expression, and desirable social attitudes. Many young children develop specialised patterns of behaviour for various environments in which they are placed. These include one pattern for the home, with particular variations for father, mother, grandmother, or aunt, and quite another pattern for the playground or the laboratory school, where other little children of the same stages of de-

velopment are constant companions.

Another basic phase in the social and emotional development of the child is in learning to relate one's own needs to the needs of others. The child's individuality must be guarded at all costs, but not at the expense of the happiness of others. The best place to learn this is in the home. Many otherwise fine personalities are misfits in society because they have never acquired the habit of merging their own interests with the interests of the larger group. On the other hand, mere conformity to group living is not the goal. It is the attitude which is significant. When the child experiences the pleasure which comes from being a contributing member of a group he has learned something worth while.

Much of what we have learned about children, particularly in the last ten years, has been through the studies of scientists; the responsibilities of parents grow with the growth of scientific knowledge on child development since they must see to it that their children are the beneficiaries of such knowledge. A programme for the ideal development of all children therefore means a programme for the education of all parents. This is the programme that is being carried out in many sections of the United States and Canada.

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If there is any subject endowed with national interest it is the welfare of the nation's children. The nation's future existence, the intelligent use of its resources, the role it will play in world affairs depend on its children—whether or not they are physically fit and whether or not they are trained in self-control, in respect for the rights of others, and in understanding of their own rights and obligations. That the first responsibility must rest with the nearest government—the state, the county, and the municipality—is the reason why the role that the Federal Government must play in the training of children is that of an intelligent and interested co-operator, ready to assist but not to control or hamper.—Miss GRACE ABBOTT.

## *The Education and Service of the Nurse*

"In a somewhat perplexed frame of mind, as I have wondered what ordinary practitioners, such as you and I, could do, it has seemed to me that we were comparatively helpless except in one way, and that particular way is this—that we, in our contact with nurses, in every relationship, whether as teachers of nurses in the hospital or as complementary agents with the nurses in the care of the sick, must try to make every nurse feel that she is indeed a part of the broader, wider art and science of medicine; that she is just as important in her own sphere as the doctor is, and to keep her interested in the patient and in the patient's problems by explaining things to her as we go on, explaining incidents of the illness; praising her at times instead of ignoring her, to a certain extent "high-hatting" her, as the expression goes, and making her feel perhaps that her services are not appreciated. I think we are all guilty of that. I haven't the slightest doubt that we are.

"If I may say a word remotely personal, I received a month ago a letter postmarked 'Philadelphia,' which was written in a trembling hand; it looked like the hand of a very elderly person. I opened it and it contained a very large number, perhaps fifty enclosures, slips of paper, and a very brief letter which read: 'Dear Dr. Cheever; I venture to write this to you because I think you will be interested in these mementoes of a member of the profession who has died and whom I revered very much.' It went on to say that the

writer was a nurse who had graduated from the Boston City Hospital some forty-five years ago, and had been in the practice of her profession ever since. She said that she had not had a moment's unhappiness in that profession; that she had loved every bit of it; that she was now superannuated and practically retired, pensioned in the family which she had served long and faithfully, and that she was content to realise that her work was about done. The enclosures which she sent were prescriptions, memoranda and notes made by one of the older surgeons who is now dead, which she had preserved. Of course the prescriptions didn't amount to anything in particular, but the notes were memoranda written at the bedside for her guidance in the care of a patient, and every now and then at the bottom of the memorandum for her guidance was written a word or two of commendation of her work the night before. She had preserved them all those years, and it was evident from the manner of her writing that they constituted a part of the intense satisfaction which she felt in her profession.

"If we can, as physicians, have the same relationship with nurses and make only a few nurses, or perhaps one nurse feel that her profession is worthwhile, I think it would do something, at any rate, to solve the problem which we are discussing tonight."

David Cheever, M.D., "New England Journal of Medicine." "The American Journal of Nursing," April, 1929.

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### A YEAR BOOK

The School of Nursing of the Ontario Hospital, London, has recently published a very attractive Year Book, the first venture of this kind by the school. Beautifully illustrated and containing several excellent contributions, this Year Book amply rewards those who assumed responsibility for its appearance. Elsewhere in this issue is published one of these articles, entitled "Throwing Light on a Dark Subject," which is a timely contribution from a young nurse.

## *The Call of Eternal Youth*

By MABEL E. FINCH, Winnipeg.

May I express to you my appreciation of the great honour you have conferred upon me in inviting me to the Annual Meeting of your Graduate Nurses Association, to bring a message to the young graduates, those whose faces are aglow tonight in anticipation of the new life they are about to enter.

They are imbued with the true spirit of Manitoba, that word whose lyrical Indian meaning is, "The Land of the Great Spirit". Perhaps nowhere is that spirit more fittingly expressed than in the stately grey stone structure that rises in the centre of our capital city, the Legislative Buildings. In majestic dignity they stand, "As a symbol of faith and belief in the future generations of the Great West."

Above the tower and above the dome, in bright relief against the azure sky, is poised the golden bronze figure of a runner. This is the celebrated French sculptor Gardet's conception of the soul of our West, and typifies Eternal Youth, the Spirit of Enterprise.

An incident in connection with this figure may be taken by us as a message of faith in our land. It was cast in a foundry in France about seventy miles from Paris. During the war the foundry was bombed and completely destroyed, this figure alone emerging unharmed from the wreck. Hastily it was rushed to a seaport and put on board a boat bound for America, but before the boat drew out from port it was commandeered for the transport of American troops. For two years the boy lay in the hold of the vessel, travelling back and forth in the war zone, in constant danger of being torpedoed. Finally, the war over, it was landed in New York and shipped to Winnipeg, to become the emblem of our Province.

Its attitude is that of a runner, indicating that we are not content to stand still. Under his left arm he carries a golden sheaf of wheat, typifying that "Labour provides the means by which man's bounty is obtained". And in his right uplifted hand is a torch, the call of the Spirit of Enterprise to carry the light of education, of health, of high ideals, to the furthestmost parts of our province. Who is better fitted to answer that call than the youth of our land?

But before you answer, let us consider a moment what are the requisites to join in this race?

As we look we will note that the face of the runner is turned northward. He who is counted worthy to enter must be able to face unflinchingly, if necessary, the bitter blasts of the Arctic. He, also, who would become a torch-bearer must have vision that reaches far beyond his native haunts—instead of dreary wastes in the Northland he must be able to visualise the great Cambrian region, with its wealth of mineral resources; lakes teeming with fish; forests stretching forth their arms with pulpwood; wilds abounding in valuable furs; mighty rivers latent with power; a port, with industries' ships thronging its waters.

As we listen we can almost hear the words of the poet pass to us from the lips of the runner:

"Only have vision and bold enterprise,  
No task too great for those of unsealed eyes;  
The future stands with outstretched hands,  
Press on and claim the world's supremacies."

It was vision that over one hundred years ago brought a band of noble adventurers to our most northern port. To them our hearts go out in gratitude for the heritage which we now enjoy. But, you say, are there any today with clarity of vision who have so steadfast a faith? Again we answer, yes, the miners—they who have gone into the Northland and have converted barren

rocks into copper, zinc, lead and gold fields.

Strange as it may seem, these explorers who have answered the call are in many respects typical of the young graduate nurses entering their new fields of endeavour.

1. The essential qualities of a successful miner are courage, faith and devotion. Are these not the very foundation stones of the nurse's success? It is courage that puts backbone into ambition so that instead of a willow wand we are able to enjoy the protection of the sturdy oak. Courage quells storms because it sees through them and beyond them. As Barrie says, "There is nothing else worth speaking about but courage. It is the lovely virtue—the rib of Himself which God sent down to His children. Courage is the thing. All goes if courage goes." With courage go hand in hand faith in yourself and devotion to your profession.

Perhaps no finer exemplification of these virtues is to be found than the life of the late Baroness Mannerheim, whose magnetic personality and ineffable charm won for her the Presidency of the International Council of Nurses. At all times and on all occasions, she had herself in perfect command, and her devotion to her profession was revealed in her all-enveloping love for humanity, which expressed itself in constant self-denying service. To the nurse who would grow in grace and perfection, surely no finer life stands as an inspiration.

2. The second great task that confronts the nurse, as the miner, after adequate preparation, is that of locating. Where shall the claim be staked? This is always a problem, but to you, not confronted with the almost insurmountable difficulties of the miner, for wherever a nurse locates she will find ore, rich enough for development: ore in the form of unenlightened humanity awaiting the touch of the skilled hand to transmute the dull metal into shining gold.

Some of you may answer the call of the Far North literally and learn that the miners' problems are your prob-

lems. Fifty miles north-west from The Pas lie the mining centres of the Mandy and Flin Flon, the former with its attractive record of \$2,000,000 worth of copper as its output during three years of the War; the latter with its miners' cabins sheltering 200 men and their families. Thirty miles beyond, at Island Falls, another 300 men engaged in power development. Or directly north from The Pas, a distance of forty-five miles, you may travel to the prosperous copper-zinc centre of Sherritt-Gordon, where several hundred people are congregated in log cabins, and where in a few years' time they expect a town of a thousand. All these are busy, stirring little mining centres, composed of motley groups, ranging from the unskilled, unkempt foreign laborer to the highly skilled mechanic and engineer. Possibly nowhere is there greater need of health teaching than in these towns that spring up in the night, people huddled together with no provision for sanitation or health facilities.

Others may turn your eyes toward the seaport of Fort Churchill, where the old world will shortly meet with the new in exchange of merchandise. There, this autumn, will ring out the deafening blows of myriads of hammers, vying with each other in the erection of elevators, warehouses, stores, hotels, restaurants and residences, in the province's model town of Fort Churchill. In due course, as an essential part of that model town there will no doubt be a model hospital, an opening surely for the courageous nurse who loves to watch the stately ships riding on the bosom of the sea in summer, and in winter, to revel in the Arctic stillness, "where silence itself aches with the intensity of winter's frosts".

Other outlying districts there are, too, not so far northward, which call for the missionary type of nurse. Lying between the lakes are numerous scattered settlements of English-speaking people. A few years ago one mother wrote saying, "We are a little English settlement twenty-five miles from a doctor or a nurse, with im-



passable roads almost the entire year. We feel our handicap keenly, especially when some one passes away because of lack of proper medical facilities. Is there any way that you can help us?"

Grouped in clusters between these are numerous foreign settlements, Ukrainians, Poles, Germans, Galicians, many who have had no opportunity for health education in their home land and who face almost the same conditions in our province. True, we have a few heroic nurses in Red Cross nursing outposts, who in addition to their nurses' duties are acting as homemakers, guides and counsellors, the one ray of Canadian idealism among a new people. But, as yet, we are only touching the fringe of the problem. As nurses, the call comes to you. How can you help them?

Coming more closely in, we have our large, well-populated rural areas, some served, others waiting to be served by private and public health nurses. In many of these centres education is beginning to make itself felt and people are realising that health preservation is a process of right living, and therefore an essential part of the education of the home and school. This knowledge has led to the demand for public health nurses as residents of rural communities. Too great appreciation cannot be expressed by the mothers for the service they are rendering in their free baby clinics, in their health teaching in schools, in the instruction given to mothers. But statistics show that Manitoba's maternal death rate is still the highest of any province in the Dominion. The call of Eternal Youth comes to you to save the country's people.

3. Before the precious ore, human lives, can be saved there must be drilling, sinking of shafts, and excavation, and this requires the co-operation of many. As Ruskin says, "We must see each other's and our own problems as jewels, and together work for service to humanity".

Fortunately for the nurse there are individuals and groups in every community who are anxiously awaiting health instruction, such organisations as the United Farm Women of Mani-

toba and the Women's Institutes. They will gladly co-operate in arranging for courses of health lectures, free baby clinics and addresses at meetings.

To the private nurse in the home comes a special opportunity for service. The anxiety for the one who is ill creates an atmosphere where she can impart health instruction that will never be forgotten. By her words of wisdom she can help hasten the time when the whole province will be adequately served by public health nurses.

4. The opportunity today is for nurses who see the world as their field of service; who regard every life as an inexhaustible mine. True, there may be many lives you will touch that will not appear to be precious. The discovery of the first diamond at Kimberly was made by a child who picked up a pebble on the banks of the Orange River and took it with him into Grahamstown. There Dr. Atherston identified it as an unusually fine specimen of a diamond, and it was sold for \$2,500.

Every life is a diamond in the rough. You are the trained, skilled diamond-cutters, who can release the glory of the hidden gem. To you, today, comes the call of Eternal Youth, to join in the race, to be courageous, to have vision, to hold steadfast your faith. Then, in the embers of the dying sun, when you come to look back over your pathway you will find it strewn with diamonds. Some sparkling with ruddy, ruby lights: the mothers, whose lives you have been the means of preserving to their little ones. Some shedding forth a soft amber luster: those who have been saved by you from years of illness and are quietly endeavouring to follow your health precepts. Some sending forth blue and violet rays: those who will end their lives on beds of suffering but whose pain has been relieved by your tenderness. Some resplendent in their pure, white iridescence: those lives to whom your coming has brought a new vision who have been purified by your presence.

This is the reward of those who are faithful. These are the gems in the nurse's diadem.

## *Reduction in Cancer Mortality*

The International Cancer Conference convoked by the representatives of the British Empire Cancer Campaign between July 16th and 20th, 1928, gave an opportunity for the discussion, among other subjects, of the best means to detect malignant growths early and cure them completely. Speakers from many countries pooled their knowledge in this field, and the result was a remarkably unanimous consensus of opinion. It was generally agreed that *early* diagnosis followed by *early* and skilled treatment offer very good chances of a complete cure. We may here quote one of many facts—not theories, hypotheses, hopes or speculations—giving incontestable proof of the benefits of early diagnosis and treatment. In the town of Leeds, an analysis of the cases of cancer of the breast operated on before the growth had spread beyond the breast, showed that 90 per cent. had had no recurrence ten years later and were presumably cured.

Some striking figures concerning cancer were given by Sir John Robertson in Birmingham, where over 1,200 deaths from this disease occur annually. In the case of deaths from cancer of the breast, the average interval between the detection by the patient of a lump in her breast and seeking medical advice was ten months. The pity of it! He concluded: "We have learned in recent years that early removal gives a fair chance of cure in cancer. The problem, therefore, seems to me to be one of educating the public as we did in the case of tuberculosis to apply at once if any doubt arises in the mind."

In the past, the diagnosis of cancer has been considered as synonymous with a death-warrant. Now, figures, such as those quoted from

Leeds, show that when the disease is in an accessible position and is treated early, it is curable. The problem resolves itself then into a search for means to assure early diagnosis and early treatment.

In this connection many roads leading to the same goal have been explored or projected. One of them was discussed by Dr. A. Cook, of Cambridge. As he pointed out, 5,290 women die of cancer of the breast every year in England and Wales—roughly twice as many as die of appendicitis. He considered that the only possible means of early discovery is by routine examination at a breast clinic once a year. In a town of 100,000 inhabitants, this plan would mean that about eighty women would be examined every day during 250 working days in the year.

One of the most interesting and encouraging contributions to the discussion was made by Dr. George A. Soper of New York, who described the work of the American Society for the Control of Cancer during the past fifteen years. By every means known to official and voluntary health agencies, it has put authentic information about cancer before the public. Short periods of intensive health educational activity, known as "Cancer Weeks," have been the means of teaching thousands the elements of cancer. On one occasion a "Week" was held simultaneously in all parts of the United States; on another, the campaign was taken up in one part of the country after another in accordance with a pre-arranged schedule. An idea of the magnitude of the audience reached may be given by the fact that, in November, 1927, a series of sixteen educational articles was published by over 500 newspapers in the United

States with an aggregate circulation of over 10,400,000 copies a day. Allowing four readers to each copy, this information was placed in the hands of about 41,000,000 people every day for over two weeks.

What has been the result of all this educational work? Dr. Soper said: "Physicians are making their diagnosis and applying the treatment required more promptly. Figures supplied by the Pennsylvania Cancer Commission in 1923, based on investigations made in that state thirteen years apart, have shown that the educational work has cut down the period between the discovery of the first symptoms in superficial cancer and the first call on the doctor 20 per cent., and in cases of deep-seated cancer nearly 50 per cent. The delay due to the doctor has also been reduced. The time between first consulting the physician and the operation has been reduced about 65 per cent. in superficial cancer, and in deep-seated cancer 67 per cent. Evidence from other parts of the United States has, in general, confirmed these results."

It will be observed that Dr. Soper referred to two distinct phases in the career of the patient suffering from cancer: the first phase lasting from the appearance of the first signs of cancer to the first medical examination, the second lasting from this examination till expert treatment is started. To shorten the first phase is a matter of educating the public. To shorten the second phase, doctors must keep their knowledge of cancer up-to-date. This was a point on which Professor Blumenthal of Berlin insisted most emphatically. But of what use is it for a general practitioner to know what to do with his patient at once if she

does not come to him till the disease has advanced to the inoperable stage?

To do so, certain elementary rules must be followed. Dr. W. Allen Daley of Hull has described them in detail. His equipment includes the short leaflet in plain, popular language, notices in the press, public lectures, health exhibits, posters, films. Sporadic efforts are not enough. In this matter, as in most other important undertakings, an organisation which provides for a complete and well-sustained campaign is essential.

In every community and in opposition to every movement, however laudable, there are always to be found critics anxious to put a spoke in the wheel of enterprising pioneers. The education of the public about cancer is no exception to this rule. The opponents of an educational campaign would smother it by insisting that educational campaigns degenerate into scare-mongering and result in outbreaks of cancerphobia and neurasthenia. But however carefully this criticism is examined, it is impossible to find more than two classes of persons concerned: those who are and those who are not suffering from early cancer. The first would surely benefit from advice, which would lead them to an early medical examination. As for the remainder, they would, if alarmed, in most cases consult a doctor and in due course be reassured. As has been very aptly said by Sir Berkeley Moynihan, "if you do your educational work properly, you do not, indeed, frighten them to death, but you frighten them to life."

(From the Secretariat of the League of Red Cross Societies.)

## Department of Private Duty Nursing

National-Convener of Publication Committee, Private Duty Section,  
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### *Constipation: Its Cause and Correction*

By Dr. N. A. PAGE, Department of Internal Medicine, Lockwood Clinic, Toronto

There are few, if any, better definitions of constipation than that given by Ludwig Kast, in which he has expressed himself thus: "Constipation is a disturbance of intestinal function characterised by the insufficient or abnormally retarded elimination of intestinal contents." It is my intention to deal only with the so-called functional constipation, though it should always be remembered that careful consideration should first be given to determine whether or not the case in point is a member of this large group, or whether actual disease underlies the condition. If any doubt remains in the mind of the doctor, any organic diseases of the type of cholecystitis or chronic appendicitis, should be eliminated. Failing this, proctoscopic examination should be made and complete x-ray pictures be taken of the stomach, small bowel and colon.

The question of the importance of this symptom to the welfare of the patient next arises. Here we find a great diversity of opinion among authorities. Some claim that it is of the utmost importance, since it underlies so-called auto-intoxication, which is popularly referred to by patients as "poisons" in the system; others believe that it bears directly on increased blood pressure without kidney or other demonstrable disease; while still others associate it with low blood pressure. There are those, on the other hand, who think that unless constipation occurs to a degree of severity approaching obstipation, it has little, if any, significance. Whatever one's opinion on the subject may be, the question cannot be disputed that, in the mind of the layman, constipation assumes a most important role. Our

daily newspapers are filled with advertisements for various patent preparations alleged to relieve or cure the condition. This indicates the position it occupies in the mind of the public. And, since we are, in a sense, the servants of the public, it is our duty to endeavour to deal with the condition intelligently.

Out of three hundred consecutive cases reviewed there were found to be one hundred and twenty-six who gave constipation as one of their complaints, that is, forty-two per cent. In addition to these, there were thirty-seven who, on being questioned, stated that they had had some trouble in this regard for many years. Thus, if such are included in our figures, the percentage is raised to fifty-four.

#### DIAGNOSIS

In diagnosing constipation, the first essential is to ascertain whether or not the patient is truly constipated. Indication of this is found in the stools. The truly constipated will give a history of passing hard, dry faeces. Many patients are found who believe themselves to be suffering from this condition, who, on being questioned, report the stools as of normal consistency. This is not true constipation, since, if there is a delay in the passage of the food residue in any section of the intestinal tract, fluid content must be lost, with the result noted. A more accurate estimation may be arrived at by the administration of carmine, given in ten-grain capsules; the evidence of the excretion of this dye will occur in the normal individual within twenty-four to forty-eight hours and will be complete in seventy-two hours.

The old classification, spastic, when the bowel is in a state of increased muscular tone, and atonic, when there



is an associated flaccidity, is discarded by Erdheim, though it would seem that it is still of service, if one remembers that there may be, in the one patient, a combination of the two types, and that each large division is again subdivided into several branches.

Either type may be most accurately and readily diagnosed by x-ray methods; the atonic being shown by the large, somewhat relaxed colon with deepened haustra; the spastic by the small, constricted bowel. Irregularities, however, may occur, with relaxation in one part followed by constriction without organic obstruction in another. This will complicate the picture and the treatment. It is neither desirable nor necessary to submit all patients to this expensive mode of diagnosing their condition. If, however, any possibility of organic disease exists, it is perhaps not out of place for us to stress again the importance of these measures.

The spastic type is usually found in the highly strung, so-called neurotic, individual, and in the great majority of these, the sigmoid colon, and sometimes even the entire colon, may resemble on palpation a firm rope-like mass which is invariably tender. The atonic type, on the other hand, is usually found in the otherwise healthy individual, or in those of the lethargic type often living a too sedentary existence. The colon of such is neither palpable nor tender. Boborygmus is often noted and there is usually a lack of tone in the abdominal muscles, with a resulting visceroptosis, that is, the organs lying at a lower level than is their usual site. One is too prone, however, to diagnose visceroptosis as the cause of the associated constipation. Ludwig Kast feels that such is never the case, though it may occasionally be an irritating factor. Even radiologists now hesitate to consider displaced or slightly kinked colons to be of great importance without signs of associated disease producing this abnormality.

Rectal constipation is often allotted a separate classification, though it is actually an atonic form, readily diag-

nosed by complete rectal examination, the rectum being found lax, distended, and usually full of hard, faecal masses. This may be caused by repeated enemas; by the presence of haemorrhoids, with resulting pain without defecation and consequent suppression of the act, first conscious and finally sub-conscious; or it may be predisposed by a congenital tightness of the muscle closing the anus.

Before dealing with the cases under consideration one might mention the possible complications of any one of these three forms. Colitis may result from damage to the intestinal wall, this alternating with constipation, though in such cases malignancy must be watched for particularly. Fissura in ano, pruritis ani, and haemorrhoids must be added to the list. When one remembers that actual ulcerations may in turn serve as a focus which may act like other foci in the body, such as teeth and tonsils (though showing an apparent preference for the abdominal organs, the gall-bladder, appendix, kidneys, etc.), one is impressed still further with the importance of this subject, which is too often lightly dismissed by many of us.

#### ETIOLOGY

Considering in somewhat greater detail the etiology of constipation, there are numerous factors to be considered, many of which are the direct result of our civilisation. Even in prehistoric days when, in the process of development, man assumed the upright posture, gravity was given a greater chance to favour ptosis. This was further aided in a later stage of our existence by the increasing sedentary nature of our lives. But, as before explained, many patients with a marked degree of visceroptosis enjoy normal evacuations, and so this must be considered as only one possible link in the chain. In women, pregnancy would seem to produce an increased tendency to this complaint. Here, three factors may play a part: first, the general laxity and resultant weakness of the abdominal musculature; secondly, the common occurrence of haemorrhoids at the time of, and preceding, labour,

with the resultant tenesmus and sub-conscious suppression of desire; and, thirdly, the mechanical interference during the middle and latter months, with subsequent habit formation. Lack of exercise, too, plays a part, though it is questionable if it is so great a factor as is popularly believed. Patients in hospital may be controlled without catharsis by a rational diet-combination of carbohydrates and fats. It is claimed, on the other hand, that postmen and policemen are inclined to constipation. Since none of such is included in our series we cannot contribute any figures on this point. However, we do find many farmers suffering from constipation. Their diet, as a rule, is adequate and wholesome, somewhat rough in type, supplying, one would think, sufficient volume and residue; nor is there any lack of exercise in their lives. But, on investigating their history further, we find that on leaving the house in the morning they often spend the entire forenoon in the fields, and on their return the optimum time for evacuation has passed. This might likewise apply to postmen and policemen.

The drinking of water is also of importance, though experience does not lead us to believe it to have so marked an effect on the bowel as is generally supposed. It is, without question, an excellent diuretic, and serves its part in carrying away the waste products of metabolism; but few cases of constipation are cured by its use. A glass of hot water, taken on rising, may serve to stimulate intestinal peristalsis; following this, the morning meal adds its effect, and the after-breakfast habit is in this way influenced by the morning draught.

It is claimed that blood pressure has relation to constipation. Alferez, however, in reporting one thousand cases of essential hypertension, finds that only forty-six per cent. give this symptom, this being no higher than the percentage found in this clinic of all patients. Low blood-pressure, likewise, has little demonstrable relationship to constipation. Only thirty-nine per cent. of the cases here

reported showed a systolic blood pressure of less than one hundred and fifteen, thus leaving the great majority of patients well within the normal range.

Sex, also, seems to be of importance, since forty-six per cent. females, compared with thirty-seven per cent. males, complained of constipation. No doubt the difference is explained, to some extent at least, by the process of child-bearing and labour.

Age, too, is a contributing factor, due in part to a changed manner of living, but principally to the physical changes that are undergone with the advance of years, the weakening of the musculature, and the general loss in elasticity of the body tissue. Unfortunately, our group does not illustrate this point, as the majority of these patients varied in age from twenty-five to fifty-five years of age.

Some members of the medical profession feel that the endocrine glands play an important part, their secretions acting directly through the nervous mechanism. Of these, the pituitary and the thyroid seem to be the most important, and though at this time the study of glands is in its infancy, and the tendency is to find in these the hypothetical source of any trouble of which the true nature is veiled in obscurity, yet we are forced to admit the possibility of this influence. All cases of intestinal stasis do not show signs of glandular hypofunction, but one rarely finds a patient giving evidence of hypothyroidism, by lowered basal metabolism, slow pulse, low blood pressure, etc., who does not include in his list of complaints faulty evacuation of the bowel. It is also true that such patients respond marvellously to treatment directed along these lines, the administration of the glandular extract often being in itself sufficient to control the condition after the preliminary restoration of normal function.

The last factor to be considered is one of the greatest, if not the greatest contributing cause of constipation, that is, the practice of habitual catharsis. Mothers, anxious for the

welfare of their children, start the regular administration of pills, castor oil, salts and similar laxatives at an early age. In many cases it is a hard-and-fast rule that Friday night is the regular time for such medications, entirely unmindful of any need for such measures. Thus, the habit is established in the young, and too often, as time passes, it apparently becomes a necessity. Cathartics are perhaps among the most constipating medications that one can take, and should be used only as emergency measures. The same remark applies to enemata. This practice is fortunately not so widely indulged in Canada as in many parts of the United States. Enemata have their purpose, but to educate people to believe that they require "internal baths," as they are called by their ardent supporters, as frequently as they require external bathing, is absolute folly.

#### SYMPTOMATOLOGY

Discussing the symptomatology of stasis with any degree of accuracy is a matter of some difficulty, and yet there is a certain sameness that occurs with persistence in such cases, making it safe to assume that there is a definite relationship between these common features and constipation. Such are: a history of fullness after meals; belching of gas a variable time after food; vague abdominal discomfort; often dull, aching pain in the lower left quadrant; sometimes a similar discomfort in the right lower quadrant, suggesting on examination chronic appendicitis, though no history of an acute attack is obtained. Headaches are common. Anorexia, foul breath, coated tongue, occasional nausea, are complained of, and sometimes regurgitation of food after meals. Abdominal cramps, gas within the bowel, pain in the back, etc., may be added to this list. In practically all cases where the gastric acidity is normal and there is no associated organic disease, these symptoms greatly improve or disappear with proper control of the bowels.

The complaints generally associated with constipation, such as tiring readi-

ly, exhaustion, nervousness, lack of reserve energy, dizziness, palpitation, etc., are not, however, so amenable to treatment. Constipation is almost invariably found associated with migraine, and is also present in the majority of cases of epilepsy. When the normal intestinal function is restored there is usually some improvement in the symptom complex, but as it can be classed only as an improvement, one is forced to conclude that it is but one of several factors at work.

#### TREATMENT

And now, in conclusion, a word must be said as to treatment. No set rules can be applied as a routine, since the procedure to be adopted must of necessity vary materially with the type and with the cause in each individual case. We have indicated certain measures throughout. Unquestionably, a normal healthy life is essential, paying particular attention to the regularity of one's habits, to meals and hours of sleep. A glass of water on rising has certain benefits, the mechanism of which we previously explained. The time for going to stool should be definite, and the optimum is, without doubt, immediately following the morning meal. The position at the stool is important, the knees well flexed on the abdomen. The diet is most essential. There are few patients with functional constipation who will not in time be able to carry on normally on a diet rich in carbohydrates such as fresh and stewed fruits, figs, prunes, green vegetables, sugar, etc. Roughage may be obtained through whole wheat bread, bran muffins, etc. As a rule, tea, cheese and excessive meat-eating should be avoided. Excesses of fatty foods should likewise be eliminated, though it is interesting to note in this regard that Florence H. Smith reports excellent results in the treatment of constipation by high fat feedings. Her prescribed diet consists in protein 66, carbohydrates 164, fat 224, which she states will control even the most persistent cases in three to five days, though she reports that a very occasional patient has resisted treat-

ment for as long as three months. Psyllium seeds, flax seeds, bran, etc., are of marked benefit in many cases, supplying the necessary bulk for stimulation of peristalsis. Yet, these should be introduced with care in the case of patients who have been on soft bland diet for long periods, as they may by this sudden radical change be markedly upset, and the co-operation and confidence of the patient is lost before treatment is well inaugurated. Cathartics, enemas, etc., should be discontinued, though in the most obstinate cases it is impossible to suddenly accomplish this. A little cascara may be given primarily, but the importance of gradually diminishing this cannot be over-stressed. Small retention oil enemas are often useful in the presence of hard, impacted faeces, such as are found in rectal constipation. Soap-suds enemas of the usual type should only be used when absolutely necessary.

Massage, while used by many, does not find a supporter in Soper. The purpose of this massage is to stimulate peristalsis. It is questionable if it accomplishes this, and undoubtedly the intake of food forms a much more reliable stimulant. It is, however, still employed by many physicians, the massage following the lines of the colon and being of a gentle rotary nature. Even by this procedure, there have been several cases reported in which damage to underlying diseased organs has resulted. However, we are presupposing that such disease has already been carefully eliminated.

Mineral oil is our greatest ally in combating constipation, being second

only to dietetic measures. This, too, however, has its disadvantages, producing at times a seepage from the rectum which is found embarrassing to the patient. Fortunately, however, in its emulsified form this disadvantage is largely overcome, and we have in many cases found it of the greatest value combined with the old-time remedy, agar-agar. Several patients have recently asked whether there is any danger in the use of mineral oil as a causative factor in the production of cancer. This idea must have been obtained from some published article, but we are unsuccessful in finding anything dealing with this subject. Perhaps the idea arose from a paper by Robert Gibson in which he pointed out that seepage may produce an eczema about the anus which might in time assume a cancerous nature. However, he cited no case in which it had done so, and, as the seepage may be controlled by the use of the emulsion, it would seem safe to overlook this theory as a possible contra-indication until more material evidence is produced to support it.

In conclusion, certain drugs may prove useful in chosen cases. Belladonna is an excellent adjunct to the treatment of the spastic type; similarly, bromides and luminal are found to have a favourable effect on the psycho-neurotic patient; pituitrin is useful in those giving signs of atonic constipation; thyroid extract, which we merely mention, having dealt with it previously; and olive oil, which is useful in the under-nourished type, in the absence of any suggestion of an associated cholestyctitis.

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## *Throwing Light on a Dark Subject*

By CATHARINE HOWARD, Class '31, Ontario Hospital, London

Schools for nurses in general hospitals have yet to realise the importance of psychiatry. They have not yet sensed their responsibility in regard to this branch of nursing service.

We understand that at one time general hospitals were for the treatment of physical diseases only. The majority of them still are, and there is no doubt it is a task in itself large enough for any hospital to undertake.

But some instruction in psychiatry to the nurses in these hospitals would result in a more sympathetic attitude towards all types of patients, and unquestionably be of service to them in their care of an emergency mental case.

Take the case of a patient admitted to a general hospital suffering from a severe physical illness, which is invariably accompanied by much distress and anxiety, and, without warning, marked mental characteristics develop.

This catastrophe, unlooked for and unexpected, changes the patient immediately into a personality so different that only the experienced psychiatrist can attempt to analyse the obscure phenomena of the patient's mind. A gulf deep and wide

soon opens up between the patient and those in attendance on him.

The utter futility of trying to carry on without the co-operation of the patient is realised, and as soon as possible he is transferred to a hospital for mental diseases.

In our junior year we are instructed in elementary psychiatry, in our intermediate year we are given advanced psychiatry, and even in our junior year this study enables us to see that our most important therapy is to endeavour to procure for the patient some peace of mind.

This was the foundation of all Greek medicine, and today it is the leading measure in our therapeutics.

The specific treatment, applicable to the type of the mental disorder, is next considered. Today there are many new and different methods of care and treatment from those of a few years ago, and the present trend of progress predicts a hopeful future.

The amount of ignorance and misunderstanding that surrounds the mentally ill is amazing. It can be dispelled by nothing but some knowledge of psychiatry. For any intelligent person, with an honest desire to know something about it, there are many good books dealing with the subject in simple and readable form.

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### PHOTOGRAPHS UNDELIVERED

Information has been received that a number of photographs of the Grand Council, International Council of Nurses, taken at Ottawa, on July 3rd, have not been delivered. Any nurse who placed an order with Menzies, photographer, for this photograph and who has not received a copy is requested to notify Miss Gertrude Garvin, Stratheona Hospital, Ottawa. Miss Garvin has kindly offered to assist in adjusting any reports of non-deliveries.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *Co-Relating Health Education in a City Secondary School*

By Miss K. E. DOWLER, Daniel McIntyre Collegiate Institute, Winnipeg.

The following is a brief report upon an experiment made in co-relating health education in a city secondary school.

The experiment in question has extended over nine years and deals with the health education as taught with the regular programme in Domestic Science to the girls coming to one centre weekly from Grades 8 to 10 inclusive. The ages range from 11 to 18 inclusive; and since September, 1921, over 1,600 girls have been reached in this one department.

Domestic Science, because of its very nature, offers perhaps more co-relatives with health than almost any single subject, but we have selected from the programme followed those projects which could be carried out in almost any class room. We might add that the cost in this particular programme has only been the cost of the material for wall charts and the class room scales. The reward for such labour as it involved has been entirely in the response of the children in sustained interest, in the splendid evidences of health improvement, in weight, in appearance, class standing; and the gain toward the close of each year in cheerfulness, improved discipline and happiness.

#### OUTLINE OF ADMINISTRATION IN HEALTH EDUCATION IN DOMESTIC SCIENCE CLASSES

1. Each student is weighed and measured to find departure from the average weight for height and age. (The Wood tables were used first, and for the last three years the Baldwin Wood height, weight, age tables.) Ten per cent. below average and over 20 per cent. above average are considered the danger points.

2. Signs of positive health are taught to each student and looked for in herself and others. These signs are evidenced in condition of weight, posture, muscular development, appearance, freedom from physical defects, etc.

3. All students are encouraged to try to reach the best weight for build. Weight in relation to build is the best criterion, as it is difficult to standardise, and for average person to judge.

4. Students are reseatd according to departure in per cent. from average weight for height and age. This makes four groups for comparison in progress and for relating definite health instruction.

(1) Those more than 20% above average on "Over Weight Heights."

(2) Those safely above average weight on "Safety Hill."

(3) Those less than 10% below average weight on "Underweight Slopes."

(4) Those more than 10% below average weight in "Danger Valley." These last may be classed as definitely undernourished.

5. Members of class are urged to seek medical examination in order to find out whether they are free from physical defects and therefore, "free to gain."

6. Health officers are elected by each class to aid in administration, class initiative and record and chart keeping.

7. Health rules for daily practice are selected to suit class needs, particularly overweight and underweight conditions. It is well to have each student list her individual needs.

8. Health rule records are marked daily in a small book. These are

checked each week by the owner, and each term by the health officer or teacher. A comparison of records is made weekly.

9. Regular weighing is done once in four weeks, and measuring once or twice yearly. Records are kept and the health officers assist in the clerical duties.

10. A weight chart or graph of weight progress is made in each note book, followed by one on a large scale for blackboard use. (These could even be improvised out of wrapping paper.) Class room charts and individual weight cards may be obtained from the Department of Health and Public Welfare.

11. Health talks are given by the teacher whenever the subject or time permits it.

12. Books, magazines, pamphlets and advertisements are searched by teacher and class for health material.

13. Health posters are made, using coloured cut-outs from magazines, etc., to illustrate truths. The printing is done either by hand or with a printing set. Marks are given for this work.

14. Testimonials are written upon the subject of—"What Health Rules Have Done for Me," etc.

15. Comparisons are made between health progress and progress in individual standing in class.

16. Every food lesson is a practical health lesson. Therefore, there are numerous co-relatives between: Health and diet, and disease, adequate breakfasts, and lunches, etc. Feeding for various ages in health and disease. Sanitary preparation of food; and disposal of waste, etc. Means of rest, work, play, eating, drinking and bathing that are most conducive to good health.

The closing exercises each year are planned to show parents and friends the results of work in health education along with results of regular class room work.

Here are some extracts from the health testimonials of the students:

"The girls all seem brighter in class work because the first twelve in class

standing are all girls. The boys in this room have not had a chance to learn the rules of the game."

Testifying to improvements in health and disposition, etc.

"I have not had a bad cold all winter. After starting the health rules I felt fine and was very happy. I used to have a very bad temper, if any one asked me anything I would not answer them properly."

"Health rules have made me more lively. I have had a perfect score fourteen times and gained nine and three-quarter pounds in six months."

From a girl above average weight: "I feel much better, and am more interested in sports."

"I never feel tired in the morning any more. My mother does not know what to think of me. I never wanted to do the dishes, but now I jump up as soon as everyone is finished and do them right away."

"I will always keep my health rules if I can, and I hope always to feel as well as I do now. It is not a hard thing to keep health rules, but a good and jolly game. I feel much better and less nervous since trying to keep the rules faithfully. I have made a good gain in weight."

"At first when I was told about health rules I thought it would be a very tiresome business, but now I find it very interesting and delightful to keep a record of what I eat and how much I sleep each day, etc."

"I was a girl who had no colour, and what colour I had, I had to put on myself. One day when Miss D—, was weighing me she said, 'Eileen, why don't you try to paint your cheeks from the inside?' On my way home from school I was thinking it would be great to have cheeks with natural colour. Health rules have put roses into my cheeks and I smile a lot more."

In closing may I add, that wherever you are, I wish you success and invite your co-operation in this good cause, which will mean more happiness for all concerned.

("The Western School Journal," June, 1929).

## *The School Teacher's Health*

The schoolmaster has changed much of late and the schoolmistress more. On the whole, conditions are much improved in those countries which can afford to pay teachers properly, and which realise that money spent on educating children well is one of the very best possible investments. Better pay for teachers means that a better class of person, physically and mentally, is attracted to this profession, and that throughout their professional careers, teachers can take better care of their health and keep their own education more up to date than hitherto. But though the lot of the teacher has been greatly improved of late in some countries, we have certainly not yet reached the stage at which we can placidly and contentedly claim that all is well and further reforms will only spoil the teacher.

Dr. Arnold, of Rugby, used to say that the day he could no longer run upstairs, he would feel it his duty to retire. It would merely be a rhetorical gesture to ask what proportion of present-day teachers could pass this test; but it will be instructive to study the observations of doctors and others who are most closely concerned with the health of teachers of both sexes. In this connection there are three studies of exceptional interest, one by Professor Frank Smith, one by Mr. J. Y. Hart, and one by Dr. Letitia Fairfield. These studies not only show the actual losses from ill-health among teachers, but they also indicate the lines to be followed if the health of the teacher is to be improved. Dr. Fairfield's study was based on a series of 900 consecutive cases of schoolmistresses referred to the school medical officer on account of absence for over a month, and for sundry other reasons. The number of teachers concerned was 13,748,

and the period over which her observations were made was 12 years.

The schoolmistress, it would seem, is much more subject to ill health than the schoolmaster. The average illness of men teachers in elementary schools in London in the period 1904-1919 was 4.6 days a year, whereas, for single women it was 8.2, and for married women 9.3 days. Here is a very extraordinary state of affairs. Whereas the death-rate in England at all ages except the age 10-15 years is higher for the male than for the female, the sickness-rate of teachers is about twice as high in women as in men. In some paradoxical way it would seem that women save themselves from death by becoming ill! But there is no doubt that the comparatively high morbidity rate among schoolmistresses should be carefully studied with a view to its reduction. Dr. Fairfield gives some useful hints which both the employer and the employed would do well to note.

Among the series of 900 cases already referred to, cases of anaemia and debility figured prominently among the schoolmistresses who were absent for short intervals. Some of the causes would seem to be lack of exercise, fresh air and sunshine in town-dwellers, and too long a journey to work. Women who are tired by the long daily journey may keep fitter if they live nearer their work and get what fresh country air they can at week-ends. An excellent piece of advice with regard to food is "to be intelligently omnivorous and not to fuss." A hot, fairly substantial midday meal is to be preferred to the sardines and cheap pastry which in the past have been chosen on grounds of economy; they are not the choice of a sound instinct or of a scientific knowledge of physiology.



Many chapters could be written on the dietary of business women, but the principles involved are perfectly simple. Given the money wherewith to buy food, and time enough in which to eat it at leisure, women can be trusted to cater rationally for themselves, always provided that there is not some poor relative or an inordinate craving for finery to absorb the money which should be ear-marked for food. Such unwise diversion of funds is, no doubt, one of the considerations which have induced certain large firms to feed all their employees on the premises at an inclusive rate. For better or worse, this arrangement is seldom applicable to the school-teacher.

Laryngitis, it would seem, is being reduced because voice production is carefully taught at college; but a new cause of laryngitis among schoolmistresses is excessive cigarette smoking. The modern woman cannot be denied her cigarette; to forbid it wholesale would require more than leonine courage. But it may be gently intimated to heavy smokers who suffer from laryngitis that relief therefrom is largely a matter of self-discipline. Noisy, dusty and draughty rooms are also important causes of laryngitis, and so are septic tonsils, the removal of which may often prove salutary.

Chronic indigestion and dyspepsia are fortunately on the wane among teachers. The tennis-playing, dancing woman of today has a much better chance to avoid indigestion, constipation and various other digestive troubles than her pink-nosed predecessor with her bottle of bismuth mixture and her flow of confidences about her stomach troubles.

The abolition, or at any rate the evolution, of the corset may also partly account for some of the improvement of women's health. It is not for mere man to speculate as to what will be the decision of woman when and if she has in the future to choose between good health and a corset which sacrifices it to the dictates of fashion.

There is another cause of ill-health, of nervous exhaustion among teachers. It is the large class. It has often been argued that the class of 30 is twice as expensive as the class of 60. The matter is certainly not so simple, and it is probable that the large class is the direct cause of much ill-health among teachers, as well as being a serious menace to the vitality of a school. Mr. Hart found that nervous and mental conditions were responsible for 12.8 per cent. of the total absence on sick leave among men teachers, for 17.4 per cent. among single women teachers, and for 17.2 per cent. among married women teachers. Hysteria may now be considered comparatively rare, but neurasthenia has become most common, and so have anxiety neuroses. The sufferings of this class of patient do not end with herself; she may spread misery around her, and fairness to all concerned demands that no step should be neglected which can prevent or mitigate nervous ailments among teachers. Let us hope that the school authorities will do all they can to reduce to a minimum this disability which inflicts such incalculable suffering on both teachers and pupils.

(From the Secretariat of the League of Red Cross Societies.)

## *A True Story*

(Contributed)

The various problems which face a Child Welfare nurse daily, would never be suspected by the man in the street, as she goes along neatly dressed in her grey uniform, walking briskly through the numerous streets of her district, climbing the more numerous stairs that "ornate" our city.

Her chief work is the welfare of the baby, but there are so many reasons why this welfare is at stake, that it would be difficult for the nurse to limit herself to the routine of the work. The town of X—, is growing, so everybody says: is it possible that one particular district cannot benefit from this actual phase of progress? Would you believe that in the year 1929 there are babies living, babies arriving in hovels, where space, comfort, mere cleanliness are utterly unknown.

Let us accompany the nurse and enter into one of them. From the baby's chart, we have already some suspicions of what we are about to witness: a mother has brought her child to the previous conference for the first time and the result of the complete physical examination by the Health Centre doctor is particularly significant—Nutrition: poor; Rickets: yes; Skin: unclean; questioned by the nurse at the centre, the mother admitted that she gives a proprietary food. "It is cheaper, nurse, when one can't buy milk or ice." Many children? "Eight, but five dead."

The nurse has given us this information "en route"; meanwhile, we observe the narrow and stuffy streets, the garbage containers of every description opened to starved cats and dogs surrounding the locality; the small grocery stores where the children are sent to buy unreliable milk and pastry half eaten by rats. A few timely remarks divert our thoughts; she is swiftly but quietly making her way through a back yard "hemmed

in" by eighteen hovels inhabited by families averaging five members each. A stable nearby completes this picture, and a white horse comes to greet us in a friendly way: it seems as though horses, cats and famished dogs are the only friends of these unfortunate people.

One of the children playing in a pool of stagnant water, runs ahead of us toward the shack and hails proudly: "Maw, the nurse!" We are invited in by a tired and anaemic looking mother; with one corner of her apron she dusts her only two chairs, murmuring an apology for the appearance of the room. This is washing day. A pile of rags, which can hardly cover a human being, lies on the floor; we look interrogatively at the nurse. Later, we learn that these rags come from the dump; it is a usual procedure in the locality to hunt up discarded mattresses, pillows, clothes, etc., etc., which are brought home by the father, while the little ones carry the lighter loads.

The following dialogue takes place between the nurse and the mother: "How are you, Mrs. Bland?" "Oh, not too bad, nurse, but me legs and me back is sore these days." "Did you go to the prenatal clinic as I advised you?" "Yes nurse, and the doctor wants me to drink one quart of milk daily, lots of fresh vegetables, and to rest as much as possible; the nurse there was kind enough to give me a paper for a place called the Diet Dispensary, and I have had better food since, but I can't rest much."

"Mrs. Bland, could you put your little ones out to play and try to rest in the daytime?" "I'll try, nurse, I'll try." "Where is your baby, Mrs. Bland?" "Come and see him, I did not wash him today, but he sleeps fine."

Adjoining the kitchen, is the bedroom. Two rooms compose this hovel: a big rusty stove, a small table, two

broken chairs, a double bed, a cheap dresser with drawers minus their handles, and two cots are the earthly possessions of this family.

The baby slept more or less, in the darkened room, swarmed with flies attracted by a soother pinned on the child's breast, as well as by the milk bottle half filled and lying aside on a blanket of doubtful cleanliness.

"Why do you not put the baby out to sleep, Mrs. Bland?" asked the nurse, "don't you think he would be more comfortable?" "I'd love to, nurse, but the neighbours' children play awfully rough and baby might be hit by a stone."

"At least, could you not use a netting in the window, to protect him against the flies; the flies are as deadly as stones." "You see, nurse, my man is not working steady at the plant, he works off and on, and it costs a lot to pay for the rent, the food, etc., etc." "Has your husband learned a trade?" "No nurse, he left school at fourteen, had to work, could not learn any."

"And yourself, Mrs. Bland, do you cook and sew well?" "Nobody showed me, nurse, me mother died when I was twelve, I do the best I can."

"Now, Mrs. Bland, your baby is awake, let us see him, please."

The mother exhibits a pitiful sample of humanity: eleven months and visibly an idiot. Moved by a maternal intuition, the mother inquires with a worried expression: "Why is

it, nurse, that my baby is not like the others, he does not grab at anything, he does not hold his head erect, he does not even stand?" A tactful conversation with the mother reveals the following facts: history of insanity on one side, poor environment, lack of hygiene.

The nurse, for once, takes us into her confidence: she would like to prevent tragedies of that sort—but how?

Since a well baby is the product of well parents, mentally and physically sound, is it not the duty of our governing bodies as well as of the man in the street, to promote with all their might the cause of Public Hygiene that covers such a great field, i.e., proper housing, careful supervision of the milk supply and of other food as well, eradication of dumps, replaced by incinerators, encouragement given to the private public health organisations, preventoria, special classes for the mentally retarded children, vocational guidance when they leave school.

We often hear that a chain is as strong as its weakest link, therefore we may state that all the movements mentioned above, constitute a long chain which is as strong as its weakest link.

It is obvious that a Child Welfare movement in a city, where the death-rate ranks abnormally high, that it has not all the support it needs.

Where is the weakest link in your city?

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#### VISIT TO STE. AGATHE DES MONTS

Two motor coaches were inadequate to carry members of the International Council of Nurses to Ste. Agathe des Monts, where they were guests of the Laurentian Sanatorium on Friday, July 12th.

Before making a tour of the buildings, the senior medical assistant gave a brief history of the institution and an outline of tuberculosis control efforts in the Province of Quebec.

The visitors were shown the entire plant which is beautifully situated with attractive garden and grounds in the Laurentian Mountains, about 65 miles north of Montreal.

Greatly interested in everything, many of the nurses were attracted towards the Post Graduate Course for Nurses, which is offered by the Sanatorium—a number voiced the intention of returning at an early date.

## BOOK REVIEW

**A Text-Book of Eye, Ear, Nose & Throat Nursing**, by Abby-Helen Dennison, R.N., Graduate Massachusetts General Hospital Training School for Nurses, Boston, Mass., Instructor Massachusetts Eye, Ear Infirmary, Boston, Mass. Published by The Macmillan Company of Canada, Toronto. Price \$3.25.

Sections of this book deal with the anatomy of the eye, ear, nose and throat separately, followed by chapters on drugs and solutions, abbreviations, instruction and procedures, treatment and surgical supplies.

Chapters are devoted to the diseases peculiar to the eye, ear, nose and throat, and special points in treatment and nursing care, also preparation for patient for the several operations, post-operative care, removal of foreign bodies, etc. Lists of instruments and equipment for operation with illustrations are given. There are special instructions for giving treatment to restive children. A very comprehensive description of equipment used, and technique followed, in Out-Patient Department is also given.

The last chapter deals with social service and follow-up work as an essential part of hospital work of today. The therapeutic measures and practical procedures described in this book are those which are used at the Massachusetts Eye and Ear Infirmary.

This book will be of assistance to instructors in outlining courses of instruction in this work; it will also prove valuable to the student or older graduates who wish to brush up in this particular line.

—OLIVE A. MACKAY,  
Miramichi Hospital,  
Newcastle, N.B.

## BOOKS RECEIVED

**A Text-Book of Anatomy and Physiology**, by Jesse Feiring Williams, Teachers College, Columbia University. Third edition, illustrated. Price \$2.75.

**Bandaging**, by A. D. Whiting, M.D. Third edition. Price \$1.75.

**Reference Hand-Book for Nurses**, by Amanda K. Beck, R.N. Sixth edition, revised. Price \$1.50.

**Home Care of the Sick**, by Norma Selbert, R.N., B.S., Assistant Professor of Public Health, College of Medicine, Ohio State University. Price \$1.00.

All these books are published by W. B. Saunders Company: Canadian agents, McAinsh & Company, Ltd., Toronto, Ont.

**A Text-Book of Materia Medica for Nurses**, by Edith P. Brodie, B.A., R.N., Director of the School of Nursing, Vanderbilt University, Nashville, Tenn. Third edition. Price \$2.00.

**Principles of Chemistry**, by Joseph H. Roe, Ph.D., Central School of Nursing, Washington, D.C. Second edition. Price \$2.50. Published by C. V. Mosby Company. Canadian agents: McAinsh & Co., Ltd., Toronto.

## B.D.H. VITAMIN PRODUCTS

Pharmacists are doubtless familiar with the B.D.H. Vitamin Products, Radiostol, Radiostoleum and Radio-Malt, and with the evolution of their manufacture.

It will be remembered that until a few years ago Vitamins were entirely unknown quantities; in fact, it was as recent as 1912 that Sir Frederick Gowland Hopkins made known his classical discovery that to maintain animal life the diet must contain in addition to the substances generally accepted as dietary essentials, a sufficiency of accessory food factors, or vitamins as they are now known.

At the present time the existence of at least five vitamins is recognised, and of these it appears that the addition of Vitamins A, B (which includes B1 and B2) and D as extra adjuncts to the normal diet is particularly essential since the common foodstuffs have proved to be deficient in these vitamins.

Biochemical research on the synthetic production of Vitamin D had been carried out for some years; it was only in 1927, however, that research workers at the National Institute of Medical Research, Hampstead, discovered that ergosterol by irradiation with ultra-violet light becomes converted into Vitamin D. At the time when the report of the work was published The British Drug Houses Limited—already had studied for some time the antirachitic effects of ultra-violet light. They had also manufactured ergosterol. With its experienced scientific staff and with its technical equipment this company was able in a short space of time to set up the manufacture of ergosterol, and with the advantage of previous work and experience, to activate it under conditions which do not lead to the formation of toxic products. It is due, therefore, to the pioneer work of The British Drug Houses Limited that Vitamin D in the form of irradiated ergosterol was made available for the medical profession within a week and within a month its manufacture in unlimited quantities was established.

The British Drug Houses Limited manufacture ergosterol, purify it and, within strictly controlled limits, irradiate it with ultra-violet light. This irradiated ergosterol is identical in its properties with Vitamin D and is known as Radiostol.

The British Drug Houses Limited have not only been the pioneer manufacturers of Vitamin D but they have also evolved a special process for the manufacture of Vitamin A. After a considerable amount of research work in the B.D.H. laboratories this vitamin was extracted from an entirely new source and utilised for the first time by the B.D.H.

Vitamin D is not only available by itself as Radiostol, but also in combination with a concentrate of Vitamin A in a preparation known as Radiostoleum. Another B.D.H. vitamin product of repute is Radio-Malt, which contains all three Vitamins A, B and D.



## News Notes

### BRITISH COLUMBIA

Miss Margaret Kerr, B.A.Sc. (Nursing), a graduate of the five year course of the University of British Columbia, 1927, has obtained her Master's Degree from Columbia University, New York. Miss Kerr served for a time as a member of the school nursing service, in Nanaimo, B.C. Receiving a Rockefeller Scholarship, she attended Columbia University, and later studied public health under the auspices of the Rockefeller Foundation.

### MANITOBA

A joint meeting of the Manitoba Association of Registered Nurses and the Manitoba Hospital Association was held in Winnipeg on September 12th and 13th.

Business sessions were held separately. Members of the M.A.R.N. held a general discussion of the Survey of Training Schools (made in 1928), and amendments to the Nurses Registration Act.

Guest speakers at the joint meetings were: Miss Mary E. Gladwin, Superintendent of Nurses, St. Mary's School of Nursing, Rochester, Minn., whose subjects were: "Value of Training School Inspection and the Future of Nursing Education," and "Value of Standard Technique in Communicable Diseases"; Dr. F. W. Jackson, Communicable Disease Section, Department of Health and Public Welfare, who spoke on "Communicable Diseases and the General Hospital"; and Dr. Harvey Agnew, Secretary, Department of Hospital Service, Canadian Medical Association, who prepared a paper on "Observation on Hospital Trends in Canada," which was read by Dr. G. S. Young, Assistant Professor of Medicine, University of Toronto.

**BRANDON:** Dr. Mary McKenzie has recently joined the staff of the Hospital for Mental Diseases.

Miss E. McNally represented the Brandon Graduate Nurses Association at the I.C.N. Congress. Others attending were: Misses S. Birtles, C. McLeod, E. Birtles, D. Cameron, I. Schofield, H. Meadows, and J. Fenton.

Mrs. (Dr.) Geo. J. Miller (Annie Francis), of Fort Frances, was a visitor to Brandon recently.

**GENERAL HOSPITAL, WINNIPEG:** Appointments: Misses Ethel Wilson (1929), and Enid Brown (1929), to the staff, General Hospital, Ambrose, N.D.

Miss Helen Holloway (1924), to the staff of the hospital at Minnedosa, Man.

Miss Iris Bennett (1927), to the staff of the Social Service Department, Psychopathic Hospital, Winnipeg.

Miss Elizabeth Pearston (1924), to the position of lady superintendent at the hospital at Grand Prairie, Alta. Miss Pearston was a member of the teaching staff for the past five years.

Miss Jessie Munro (1923), to a position as X-ray technician in Saskatoon.

Miss Mary Cameron (1926), to the staff, Winnipeg General Hospital.

Miss Gretchen Gouling (1918), has resigned from the staff of the Social Service Department, Psychopathic Hospital, Winnipeg.

Mrs. Dr. Burns (Florence Cromie, 1921), of Derby, Conn., visited in Winnipeg during August.

Miss Ada Luross (1924), of California, visited in Winnipeg during July.

Miss Mabel Andrew (1923), of Hollywood, Cal., visited in Winnipeg on her return from the Congress in Montreal.

Our graduates were happy to see that among those registered at the Congress in Montreal was Miss M. Eleanor Birtles (1889), the oldest graduate of the hospital.

### NEW BRUNSWICK

**GENERAL PUBLIC HOSPITAL, SAINT JOHN:** On August 27th, Miss Elsie Shaw was tendered a shower at the home of Mrs. J. H. Vaughan, president of the Alumnae. Many pieces of flat silver were presented to the guest of honour.

Misses Inez Whipple and Chrissie Shand, were entertained at a handkerchief shower by the graduates prior to leaving for Winnipeg and Toronto, respectively.

Miss Evelyn Bedford spent her vacation in Saint John.

### NOVA SCOTIA

At the regular monthly meeting in August, of the Wolfville Branch, Victorian Order of Nurses, a presentation of \$25.00 in gold was made to Miss Mary Harry, who has been on the staff since its inception, eighteen years ago. Miss Harry, who recently resigned, has joined the Frontier Nursing Service of Kentucky, U.S.A.

### ONTARIO

#### APPOINTMENTS

Paid-up subscriptions to "The Canadian Nurse" for Ontario in September, 1929, were 1,253. Fifty more than in July, 1929.

Miss B. Parker (Hamilton General Hospital, 1914), to the staff of the Hospital, and is in charge of Ward 7.

Miss Jessie Jackson (Hamilton General Hospital, 1927), to the position of assistant night supervisor at the Hospital.

Miss Pauline Steves (Toronto General Hospital, 1928; Public Health Nursing, University of Toronto), to a position in the Social Service Department, Toronto General Hospital.

Miss Moseley (Toronto General Hospital, 1927; Public Health Nursing, University of Toronto), has been relieving on the Social Service staff, Toronto General Hospital.

Miss Janet Murray (Hamilton General Hospital, 1927), to the operating room of the Hospital.

Miss Helen Aitken (Hamilton General Hospital, 1925), and Miss Mary Lanford (1926), to the Mount Hamilton Hospital.

Miss S. Livett has succeeded Miss H. Ion on the staff of the Brantford General Hospital.

Miss T. Dawson to the staff of the Brantford General Hospital; Miss F. Keffer having resigned.

#### DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Miss Ida M. Gardiner who has been engaged in outpost duty for the Red Cross Hospital at Redditt, Ontario, has been awarded a scholarship and entered Western University, London, on September 23rd for a post-graduate course.

Misses Cora Taylor, Alberta Creasor, and Anna Coutts are all taking the Public Health Course at the University of Toronto this year.

The Mutual Benefit Association is having a drive for new members, and we would like to impress on all those who have not joined, the benefits to be derived therefrom.

Miss M. McFarlane (1926), former assistant night supervisor, has taken up private duty nursing.

Miss Ada Schiefele (1923), is at home on furlough from India.

Miss Myrtle Harrod (1926), has resigned her position in the operating room.

#### DISTRICT 5

WELLESLEY HOSPITAL, TORONTO: At the May meeting of the Alumnae, Miss Gertrude Ross, newly appointed superintendent was introduced to the large number of graduates present. It was with great pleasure that they welcomed her to the Training School.

Twenty-five nurses graduated on June 15. Ideal weather and the beautiful grounds of the Hospital made the setting for the colourful graduating exercises. Dr. J. E. Elliott, Toronto, gave a most appropriate address.

The new residence of the Hospital was the scene of a large gathering of graduate and undergraduate nurses, when Miss Bastedo (1915), on behalf of the Alumnae presented the Training School with a beautiful portrait of the late Miss Elizabeth Flaws. The gift was accepted by one member of each class for the school.

### QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: Miss E. Morris (1915), who has been doing summer relief work at the Hospital, has accepted a position in the Infirmary at St. Johns, Nfld.

Misses F. B. Laite (1924), who is doing V.O.N. work in Moncton, N.B.; M. Bailleul (1925), of Winsted, Conn., and G. Fitzgerald (1928), of St. Johns, Nfld., were among those who attended the I.C.N. Congress in Montreal.

Miss A. Thompson (1926), has resigned her position as night supervisor and is at present visiting relatives in Western Canada. She has been replaced by Miss B. Goobie (1929).

Miss I. Stewart (1927), has resigned her position on the staff of the Woman's Hospital, Montreal, and has gone to her home in Glasgow, Scotland, where she intends doing school nursing.

Miss Feader (1929), who did summer relief work at the Hospital has gone home to Chester, N.S.

Miss R. Miller (1928), is now with the V.O.N. in Montreal.

Miss A. MacFarland (1928), is stationed in Huntsville, Ont., with the V.O.N.

Miss V. Ford (1928), after spending some time in Nova Scotia has resumed special duty in Montreal.

Sympathy of the members of the Alumnae is extended to Mrs. W. Francis in the loss of her father.

GENERAL HOSPITAL, MONTREAL: Miss Welling has been appointed second assistant in the Training School office.

Miss Wills has joined the teaching staff.

Miss Reinauer has become charge sister in Ward "L."

Miss Donovan has resigned as night supervisor from the Woman's General Hospital and accepted a position as assistant supervisor at the Miramichi Hospital, Newcastle, N.B.

Misses H. Carmon, K. Wilson, E. MacNutt, have returned after spending the summer abroad.

The sympathy of the Alumnae is extended to Miss Agnes Bulloch in the loss of her brother.

WOMAN'S GENERAL HOSPITAL, WESTMOUNT: Miss Sholit (1915), of Los Angeles, Cal., attended the I.C.N. Congress.

Misses Margaret Paterson and Abramovitch (1929), were relieving at the Hospital during the holiday season, and are now doing private nursing in the city.

Miss Margaret Crayman (1929), is in charge of the Nursery at the Hospital.

Miss M. Blower (1928), has returned from a visit to England.

Miss Ruth Jackson (1928), is in Truro, N.S.

Mrs. Crewe (1919), spent a month in Prince Edward Island.

Miss N. J. Brown (1925), visited in Kingston, Ont., during the month of August.

### SASKATCHEWAN

The first scholarship offered by the Saskatchewan Registered Nurses Association was awarded this year to Miss Edith Amas, of Qu'Appelle, Sask. Miss Amas is a graduate of Saskatoon City Hospital, (1923) and held, on entering training, the Lieutenant-Governor's Medal for high school work and the Red Cross Scholarship.

The scholarship of five hundred dollars is to enable the student to spend one year in university, studying Teaching and Adminis-

tration in Schools of Nursing, after which she must return to Saskatchewan to spend at least two years in a Saskatchewan Training School for Nurses. Miss Amas enters McGill University this fall.

Mrs. Margaret F. Myles has resigned her position as Superintendent of the Queen Victoria Hospital, Yorkton, Sask., and enters McGill University this fall, to take a course in Administration in Schools of Nursing.

**CITY HOSPITAL, SASKATOON:** APPOINTMENTS: Miss Kate MacLean (1922), to the staff of the Sanatorium, Saskatoon, Sask.

Mrs. Ina Hill (1922), has accepted the position of Matron, Boy's College, Battleford.

Miss Jean Watson (Mountain Side Hospital, New Jersey), to position as Superintendent of Nurses, Saskatoon City Hospital.

Miss Ellen Hettle (1928), who underwent a serious operation recently, is reported to be making favourable progress. She is with her mother, 1015 South Benito Ave., Alhambra.

**REGINA:** The regular meeting of the Alumnae of the Regina General Hospital was held at the home of the president on September 12th. The secretary-treasurer reported the Alumnae to be in good financial

position. Plans were made for a tea and sale of aprons, knitted articles and home cooking.

Miss Wanley has accepted a position at the Shaunavon Hospital.

## VICTORIAN ORDER OF NURSES

### APPOINTMENTS

Miss Marion Wismer (University of British Columbia), assistant Vancouver staff.

Miss Mary McCuaig, nurse-in-charge, Edmonton District; Miss Marjorie Baird having resigned.

Miss Eileen Wright (University of British Columbia), to district of Preeceville-Clayton, Sask.

Miss Madeline Taylor, charge of the newly opened district of Regina.

Miss Mabel Fillmore (Saint John's staff), the district of Dartmouth, N.S.

Miss Faye Saunders, of Halifax, the district of Lunenburg.

### RESIGNATIONS:

Miss Clara Shields and Miss C. Van Allen, resigned from the Winnipeg staff (to be married).

Miss Mary Harry (Wolfville Branch), resigned, to take a position with the Frontier Nursing Service, Kentucky.

## BIRTHS, MARRIAGES, AND DEATHS

### BIRTHS

**ANDERSON**—On August 13, 1929, to Dr. and Mrs. Lloyd Anderson (Emily Sproule, Saskatoon City Hospital, 1922), a son.

**BENNETT**—Recently, at Toronto, Ont., to Mr. and Mrs. G. C. Bennett (Olive Bennett, Wellesley Hospital, Toronto, 1922), a son.

**DONNER**—On July 15, 1929, at Saint John, N.B., to Mr. and Mrs. George Donner (Clara Nixon, General Public Hospital, 1928), a son.

**FLETT**—On August 10, 1929, at Toronto, to Mr. and Mrs. Flett (Dorothea Burton, Wellesley Hospital, Toronto, 1926), a daughter.

**FULLER**—On August 6, 1929, at Napanee, Ont., to Mr. and Mrs. G. B. Fuller (Marguerite Pringle, Wellesley Hospital, Toronto, 1922), a son.

**GIFFIN**—On August 22, 1929, to Mr. and Mrs. William Giffin (Mildred Grady, Saskatoon City Hospital, 1925), a son (Douglas Hamford).

**GUNN**—On August 21, 1929, at Fort Frances, Ont., to Dr. and Mrs. Lynn Gunn (Melrose King, Winnipeg General Hospital, 1925), a daughter.

**HANSEN**—On May 18, 1929, at Winnipeg, to Mr. and Mrs. S. L. Hansen (Edith Archibald, Winnipeg General Hospital, 1926), a daughter.

**HARRIS**—Recently, at Mt. Hamilton, Ont., to Mr. and Mrs. Harris (Gladys Tighe, Hamilton General Hospital, 1921), a son.

**HOGEBON**—On July 14, 1929, at Winnipeg, to Mr. and Mrs. L. K. Hogeboon (Miss Watson, Winnipeg General Hospital, 1925), a son.

**LAWRENCE**—On August 1, 1929, to Mr. and Mrs. Lawrence (Grace Occomon, General and Marine Hospital, Collingwood, 1918), a son.

**MULLENS**—On September 2, 1929, at Hamilton, Ont., to Mr. and Mrs. S. Mullens (Louise Wood, Hamilton General Hospital, 1927), a son.

**MUSGROVE**—On June 25, 1929, at Winnipeg, to Dr. and Mrs. W. M. Musgrove (Thelma Mason, Winnipeg General Hospital, 1924), a daughter.

**McINNES**—On July 10, 1929, at Winnipeg, to Mr. and Mrs. Robert McInnes (Muriel Ross, Winnipeg General Hospital, 1918), a son.

**McKAY**—Recently, at Hamilton, Ont., to Dr. and Mrs. A. J. McKay (Roberta Pratt, Hamilton General Hospital, 1925), a son.

**McKAY**—In July, at Toronto, to Dr. and Mrs. Angus McKay (Ted Hanna, Toronto General Hospital, 1916), a daughter.

**PAGE**—On August 21, 1929, at Hamilton, Ont., to Dr. and Mrs. L. Page (Ethel Davidson, Hamilton General Hospital, 1922), a daughter.

**RENNICK**—Recently, at Kitchener, Ont., to Mr. and Mrs. H. Rennick (Jessie Spence, Hamilton General Hospital, 1925), a son (Bruce William).

**ROBERTSON**—On May 9, 1929, at Ipah, Perak, F.M.S., to Mr. and Mrs. D. S. Robertson (Gladys Risk, North Bay Hospital, 1924), a daughter (Margaret).

**ROY**—On June 24, 1929, to Mr. and Mrs. Stuart Roy (Hilda Merritt, Hamilton General Hospital, 1925), a daughter (Frances Ann Elizabeth).

**SINCLAIR**—Recently, at Winnipeg, to Mr. and Mrs. D. Sinclair (Gertrude Bloomfield, Winnipeg General Hospital, 1926), a daughter.

### MARRIAGES

**ALLEN—HANCOCK**—In June, 1929, at Port Hope, Ont., Muriel Hancock (Wellesley Hospital, 1927), to Clarence Allen, Newcastle, Ont.

**AUSTMAN—HERMANSON**—On August 10, 1929, Wildora Hermanson (Winnipeg General Hospital, 1928), to John J. Austman, Winnipeg, Man.

**BAIRD—MUNROE**—On July 17, 1929, at New Glasgow, N.S., Jean MacElvie Munroe (Victoria General Hospital) to Harold E. Baird, M.D., C.M., of Chipman, N.B.

**BRAIS—BREWSTER**—On August 19, 1929, at Saint John, N.B., Dorothy Louis Brewster (Montreal General Hospital, 1927), to Louis Alexis Brais.

**CHRISTIE—CLARK**—On August 17, 1929, at Hamilton, Ont., Bessie I. Clark (Hamilton General Hospital, 1928), to R. J. Christie, Mount Hamilton, Ont.

**CLARK—BRECKON**—On September 4, 1929, at Winnipeg, Lottie Breckon (Winnipeg General Hospital, 1927), to Bert Clark, Fort Frances, Ont.

**DARGAUELL—McVANELL**—On April 13, 1929, at Wiarton, Ont., Mary McVannell (Woodstock General Hospital, 1922), to Clark DargaueLL, Wiarton, Ont.

**DICKIE—SMELTZER**—On July 1, 1929, at Mahone Bay, N.S., Marion Gertrude Smeltzer to David M. Dickie. At home, Canning, N.S.

**DOLE—DOANE**—On July 10, 1929, at Barrington, N.S., J. Gunheld Doane to Howard Louis Dole, Waynesburg, Pa.

**DONALDSON—GEE**—On June 1, 1929, at Winnipeg, Gladys Gee (Winnipeg General Hospital, 1928), to Gordon William Donaldson, of Edmonton, Alberta.

**EMPEY—ELLIS**—On August 13, 1929, at Iroquois, Ont., Luella Mabel Ellis (Wellesley Hospital, 1929), to Stewart F. Empey.

**FAIRBAIRN—CRAIG**—On June 29, 1929, at Winnipeg, Kathleen Craig (Winnipeg General Hospital, 1926), to Dr. Logan Fairbairn.

**FARRELL—BARDAL**—On August 21, 1929, at Saskatoon, Sask., Svava Bardal (Winnipeg General Hospital, 1927), to Lorne Farrell.

**FENTON—SMITHSON**—In June; Marguerite Smithson (Toronto General Hospital, 1921), to Robert Fenton.

**FRASER—GORDON**—On August 14, 1929, at Grenfell, Sask., Ivy Gordon (Winnipeg General Hospital, 1927), to G. R. Fraser, Neepawa, Man.

**FRY—FIDLIN**—On August 31, 1929, at Norwich, Ont., Inez Fidlin (Hamilton General Hospital, 1927), to H. Fry.

**FULLERTON—STACK**—On August 31, 1929, at Knowlton, P.Q., Dorothy Stack (Montreal General Hospital, 1927), to Dr. Charles W. Fullerton.

**GALBRAITH—McCANN**—On August 24, 1929, at Regina, Sask., Violet McCann (Saskatoon City Hospital, 1927), to Charlie Galbraith.

**GRIEVE—MACPHERSON**—On August 20, 1929, at Vancouver, B.C., Frances Emma MacPherson (Victoria Hospital, London, Ont., 1918), to Charles Grieve, Barcoona Bay Road, Glen Osmond, South Australia.

**HEROLD—MACDONALD**—On July 10, 1929, at Burlington, Margaret MacDonald (Hamilton General Hospital, 1927), to Alfred Herold.

**HORTON—LANGLEY**—On June 29, 1929, at New Hampshire, Miss Langley of Port Hawkesbury, C.B., to Ralph Horton.

**HULL—HEISEY**—On June 22, 1929, at New York, Luella Heisey (Wellesley Hospital, 1917), to J. Hull, New York.

**JONES—GARRIOCH**—On June 19, 1929, at Sacramento, California, Jean Garrioch (Winnipeg General Hospital, 1920), to Gordon Jones.

**KING—PARSONS**—On August 24, 1929, at Cayuga, Ont., Ella Parsons (Hamilton General Hospital, 1927), to Francis King, of Cayuga.

**LEDINGHAM—DUNCAN**—On June 26, 1929, at Owen Sound, Ont., Margaret Duncan (General and Marine Hospital, 1927), to George M. Ledingham, Souris, Man.

**MARTIN—WHITE**—On May 16, 1929, at Woodstock, Ont., Luella Annie White (Woodstock General Hospital, 1928), to E. L. Martin, Woodstock, Ont.

**MERRETT—NEELAN**—On June 1, 1929, at Swan Lake, Man., Violet Neelan (Winnipeg General Hospital, 1928), to Dr. Paul Merrett, Winnipeg.



McARTHUR—FERGUSON—On August 19, 1929, Bessie Irene Ferguson (Saskatoon City Hospital, 1921), to Melvin Clarke McArthur, Toronto, Ont.

McCAUSLAND—SHERMAN—On August 15, 1929, at Toronto, Ont., Jessie Sherman (Woodstock General Hospital, 1923), to John McCausland, North Bay, Ont.

McCLUSKEY—McDONAUGH—On June 22, 1929, May McDonald (Toronto General Hospital, 1926), to Dr. McCluskey.

McKENNA—GREENAN—On July 3, 1929, at Kinkora, P.E.I., Annie Madeline Greenan (City Hospital, Charlottetown, P.E.I., 1925), to J. M. McKenna, Maple Creek, Sask.

McMILLAN—BARBOUR—On August 14, 1929, at Salteoats, Sask., Edith Barbour (Winnipeg General Hospital, 1927), to Joe McMillan, Brandon, Man.

OLSON—VAN ALLEN—In July, 1929, at Winnipeg, Catherine Van Allen (Winnipeg General Hospital, 1920), to William Olson, Winnipeg, Man.

PHIN—KOPEMAN—In August, 1929, at Hespeler, Ont., Florence Kopeman (Wellesley Hospital, 1926), to Robert Phin.

POTTER—BOUDREY—Recently, at Hamilton, Ont., Doreen Boudrey (Hamilton General Hospital, 1928), to Reg. Potter.

PUDDICOMB—MORRIS—On July 10, 1929, at Windsor, N.S., Clara Hamilton Morris to John Francis Heins Puddicombe, M.D., C.M., Ottawa, Ont.

SAVAGE—NORQUAY—On May 21, 1929, at St. Andrews, Man., Mary Norquay (Winnipeg General Hospital, 1928), to Alfred Savage, B.Sc., of Winnipeg.

SOBY—HANSON—On August 8, 1929, at Calgary, Alta., Anne Hanson (Children's Memorial Hospital, 1926), to Harold Soby, M.D. At home, Highwater, Alta.

SOUTER—HARROD—On September 21, 1929, at Palermo, Ont., Myrtle I. Harrod (Hamilton General Hospital, 1926), to W. E. Souter, Hamilton, Ont.

STEWART—SHIELDS—On June 8, 1929, at Winnipeg, Clara Shields (Winnipeg General Hospital, 1921), to Nelson Stewart, Jasper, Alberta.

SWICKER—SHAW—On September 3, 1929, at Saint John, N.B., Elsie Josephine Shaw (General Public Hospital, 1919), to G. Russell Swicker, Worcester, Mass.

TARLETON—LENNON—On August 31, 1929, at Montreal, Irene Lennon (Children's Memorial Hospital, 1926), to Gordon Tarleton. At home, Outremont, Montreal.

UREN—McGUFFIN—On June 20, 1929, Mildred McGuffin (Toronto General Hospital, 1926), to Dr. Lester Uren.

WARD—McLEOD—On September 3, 1929, at Winnipeg, Man., Frances McLeod (Winnipeg General Hospital, 1924), to Stanley Ward, Winnipeg.

WEBSTER—LYKE—On August 24, 1929, Marie Lyke (Saskatoon City Hospital, 1927), to David Webster, Saskatoon, Sask.

#### DEATHS

HOLLOWAY—On July 18, 1929, Edna Kathleen Holloway (Victoria General Hospital, Halifax, 1920).

JENNINGS—On July 28, 1929, at St. Catharines, Ont., Grace Jennings (Wellesley Hospital, Toronto, 1927).

PENWARDEN—On July 28, 1929, at Boston, Mass., Margaret Penwarden (Macleon Hospital, Waverley, Mass.), daughter of Rev. B. H. and Mrs. Penwarden, Windsor, N.S.

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### CONTENTS

PAGE

SURVEY OF NURSING EDUCATION IN CANADA	- - - Dr. George M. Weir	653
EDITORIALS	- - - - -	660
BREAST FEEDING IN HEALTH CENTRES	- - - Dr. A. B. Chandler	663
CARE OF POST POLIOMYELITIS PATIENTS	- - - Gladys E. Smiley	671
THE NURSES LIBRARY, GENERAL HOSPITAL, WINNIPEG	- Rachel N. Fogarty	672
MISS ETHEL JOHNS	- - - - -	674
DEPARTMENT OF NURSING EDUCATION:		
A GIFT TO NURSING EDUCATION	- - - - -	675
CONCERNING CO-OPERATION	- - - S. Persis Darrach	676
DEPARTMENT OF PUBLIC HEALTH NURSING:		
COUNTY HEALTH UNIT—ENGLAND	- - - Ruby M. Hamilton	678
BOOK REVIEWS	- - - - -	682
NEWS NOTES	- - - - -	684
OFFICIAL DIRECTORY	- - - - -	691



# Survey of Nursing Education in Canada

By Dr. GEORGE M. WEIR, Director of Survey

## 1.—INTRODUCTORY STATEMENT

A number of pertinent questions are immediately suggested by the mention of the above subject. Why have a survey of nursing education? Are there such symptoms of maladjustment of our systems and methods of nursing education to present-day social and professional conditions as would warrant a comprehensive investigation that will probably be Dominion-wide in scope? Will the survey be merely a diagnosis of certain conditions pertaining to nursing education in the various social and economic areas of Canada, or will its findings and recommendations be followed up by a concrete programme of corrective and preventive reform? Will the benefits likely to be derived from such a survey compensate for the probable expenditure of money, time, and energy involved? Are surveys in general an "American innovation" or are they British and Canadian as well? In any event, will this survey be a Canadian survey of Canadian nursing problems and with the primary aim of improving nursing conditions in Canada? Does it aim to provide a thorough-going diagnosis before prescribing treatment for our real or fancied nursing ills? It is the aim of the present article merely to suggest answers to some of the above questions. In the writer's opinion, however, reasonably conclusive answers to a number of the questions cited can be given, if at all, only after the results of the proposed survey have been made known.

The present era is somewhat disconcerting to the reactionary whose intellectual gaze is chiefly over his shoulder at the past. The unsupported dicta of sages, prophets, and oracles are no longer accepted at face value.

"These are days of surveys, investigations, experiments, scientific doubt," writes Hall-Quest. "Deduction and opinion are losing caste. Authority is being pulled down from dusty thrones and cross-examined. The millennial bias, that a thing is right because it is old, is suffering a twist into a frontal position where the past is looked at face to face and respectfully requested to divulge by what mystic process it became authoritative in the beginning. If the evidence is forthcoming and is rational or even true to experience, authority will be escorted back to its throne, which in the meantime has been well dusted by approved methods, let us hope."

It should not be assumed, of course, that opinion evidence, especially the opinions of experts, has little or no validity. Nursing education has not yet become an exact science. Indeed the very nature of some of its problems precludes a wholly scientific treatment and their solution must depend largely on the best expert opinion available. Where applicable, however, careful statistical analysis and objective investigation—basic procedures in the modern survey—are probably as far in advance of mere opinion as modern medical practice is superior to the use of incantations, leeches, and other superstitious medical practices of the middle ages.

## 2.—GENERAL AIMS OF THE SURVEY

The broad aims of the survey may be briefly stated as follows:

(a) To assist the nursing profession by crystallizing its problems and by defining and elevating its status.

It is frequently stated that the present is an epochal stage in the evolution of the nursing profession. Paralleling the advances so conspicuously being made in medical science and practice, the nursing profession

is rapidly becoming more scientific in outlook and practice, more highly specialised and socially important. There are some observers, however, who apparently doubt whether the marked development of the nursing profession can continue, under existing conditions, without the profession becoming somewhat commercialised or dehumanised. How should admission standards, for instance, be safeguarded so that the profession will retain its traditional nobility while increasing its professional efficiency?

(b) To render more effective assistance to the medical profession in its great service to suffering humanity.

(c) Primarily to promote the interests and well-being of the patient and of the public. Society is so constituted, as an organic whole, that there is a vital interdependence among its various parts, and what proves to be of real benefit to one of these parts (as the nursing profession) must also prove of considerable benefit to the other parts of the social order.

It is obvious, of course, that the aims of education—whether nursing, medical, theological, legal, or whatever the type—can never be completely and ultimately realised in a living and expanding social order. The laws of life preclude such fixity and finality. Each advance in our social evolution prepares the stage for a subsequent advance. The objectives of nursing education must, therefore, ever remain in a process of approximation rather than of complete fulfilment. The future, as the present, status of the nursing profession, so long as it possesses vitality, will bristle with major problems—economic (including administrative), educational, and sociological, as well as the merely technical. In the words of James Russell Lowell:

"New occasions teach new duties,  
Time makes ancient good uncouth—"

and herein chiefly lie the major purposes of the survey, namely, its diagnostic value concerned largely with the detection and elimination of the "uncouth" and outworn factors in educational procedures; and its

more constructive or prognostic contribution, pointing out ways and means of advance along various economic, educational and social avenues that conduce to the highest efficiency of nursing education. The personnel of the survey committee, composed of outstanding representatives of the Canadian Medical and Canadian Nurses Associations, should, in the writer's opinion, be sufficient warranty that the major aims of the survey will not be overlooked.

### 3.—SOME ECONOMIC PROBLEMS

So much for general background: let us now consider a few of the innumerable economic and other problems involved in a survey of nursing education in Canada. The matters mentioned below are suggestive only. The writer's present aim is to state a few typical problems, that indicate the need for a survey, rather than, at this stage, to offer a solution for these problems. Incidentally, it is the investigator's duty to maintain an open mind (closed at one end) until all the available evidence is presented.

Questions of demand and supply are ever to the forefront:—Is there, at present, an overproduction of nurses with consequent unemployment (especially among private duty nurses) and low remuneration? If so, to what extent does the above condition exist and wherein lies the remedy? Is the increase in the number of nurses being graduated from our training-schools proportionally greater than the increase in general population? If the present rate of increase continues for ten or fifteen years what will probably be the proportion of nurses to doctors, to patients, and to the general public? Is the increase uniform or is there a shortage of nurses in certain areas? Compare, for instance, the need for skilled nurses in rural British Columbia, rural Saskatchewan, rural Ontario, and the larger urban centres. To what extent is the problem one of the effective distribution and control of nursing services? Does the above problem bring us dangerously near to the delicate question of socialising nursing

services (under state management and control) and would such control involve a form of socialism or communism somewhat foreign to Canadian outlooks and modes of thought although recently advocated in certain rural sections of Canada? To what extent, if any, would the above expedient involve a system of compulsory health insurance and is the latter a new form of taxation under disguise? What are the actual conditions of unemployment among the nurses in Canada? Obviously this question would involve a careful statistical study.

Regarding nurses' fees: Are these frequently too high for the average patient to pay? Are these fees higher relatively, than, for instance, the remuneration of high or public school teachers? Surely the nurse is as entitled to be justly rewarded, on the basis of skilled services rendered, as are the members of other professions. Do nurses, as a class, receive adequate remuneration to enable them to live decently, to save for old age and the proverbial "rainy day", to enjoy reasonable recreation, and to keep abreast of the advances in their profession? How is the above situation to be remedied, if at all: e.g. by more rigid selection of the nursing personnel, such as raising the admission requirements to, or the graduation requirements from, training schools? Would such elevation of standards probably tend to increase, or decrease, the number of applicants? How, if at all, should the public be educated to make a greater use of skilled nursing services? What legal or other safeguards, if any, should be taken to prevent poorly or partly trained nurses from charging as high, or higher, fees than those charged by the highly trained nurse? Are the above conditions due to unavoidable social and economic disparities that cannot be remedied except through a slow process of public education, eventually followed by legislation, or does the remedy, if any, lie close to hand? What are the controlling economic and other

factors affecting nursing services, for instance, in sparsely settled rural areas and in densely populated urban communities? Which, for instance, is the chief difficulty of the average patient—to pay the nurse, or to obtain the right kind of nursing service?

Then, too, problems of group nursing, part time nursing, etc., are the subjects of much discussion at the present time. The fact that such expedients have proven advantageous in certain sections of the United States is no guarantee of their successful application in Canada unless the conditioning factors are equivalent in the corresponding areas where the experiment is tried. For instance, would the successful application of this experiment (outside of hospitals) involve a zoning system, or the delimitation of areas of similar economic status especially in cities? Obviously, too, the problem is quite a different one in the average rural community. What contribution, in this connection, have such agencies as the Saanich Health Centre (British Columbia), for instance, or the Saskatchewan Municipal Doctor Scheme to make towards the solution of health problems in rural or semi-rural areas?

The above are typical of the economic and social factors involved in a survey of nursing education in Canada. The mere statement of these problems is, in the writer's judgment, sufficient evidence of the need for a careful investigation of available data before tenable conclusions can be reached. Furthermore, owing to the diverse economic and social conditions existing in various areas of Canada, generalisations would probably prove dangerously misleading. Where\* the conditioning factors are practically equivalent, as in areas of similar economic and social status, the nursing problems involved may be classifiable and subject to solution on a common basis. Obviously, too, while certain general principles may be applicable, no set formulas will provide the solutions for Canada's diversity and complexity of nursing problems. The

survey of nursing education involves not one study only but a series of studies, each of considerable scope and importance.

#### 4.—A FEW EDUCATIONAL MATTERS

The survey bristles with problems of an educational nature. A few samples may prove suggestive of the complex difficulties abounding in this comparatively unexplored field.

Are nurses-in-training frequently given too much theory, in a relative sense, and too little supervised practice in actual bedside nursing? Real education develops initiative and resourcefulness and hence means much more than the mere acquisition of knowledge. "Knowledge is power"—but only when assimilated, motivated (given a purpose that seeks expression), and rendered dynamic. The supreme test of the efficacy of education is, in the final analysis, "the emergence of appropriate conduct in life situations". How will the nurse react when thrown upon her own responsibility, as in home nursing, or when confronted with an actual problem in a practical life situation? Theory, if properly assimilated, will no doubt beneficially modify or control her reactions. Otherwise mere theory is excess baggage and probably a positive hindrance to rational conduct. There is, however, another vital aspect of the problem:—Will mere practice, without adequate theory, produce the automaton?

Again, is there anything in the charge that student-nurses are too often regarded by hospital authorities as so-called economic assets to the hospital rather than as worthwhile personalities who are being educated to become efficient leaders in health matters and missionaries to suffering humanity? In other words, is the chief interest of hospital administrators—from the viewpoint of the training school—in the training of the efficient nurse, or does this interest predominantly lie in financing the hospital? Is the student-nurse legitimate game in the field of hospital finance? On the other hand, may it not be true that the presence of the

training school is sometimes a financial liability rather than an asset to the hospital concerned? Certain investigations indicate that the latter is sometimes the case.

The question of selecting student-nurses is also of paramount importance. On what basis, by whom, and by what criteria should student-nurses be selected? What is the range in the preliminary education of student-nurses? Does this range extend from, say, grade VIII (entrance to high school) to the B.A. degree? What should be the minimum standard of preliminary education and to what extent, if any, is this question related to that of demand and supply? It is probably true that certain applicants with only grade VIII standing may have superior nursing aptitudes and a higher intelligence than some graduates in arts possess, but no thoughtful person would, solely on this account, argue for the lower academic standard. The logical conclusion of such fallacious reasoning would mean the elimination of any preliminary education for student-nurses.

It would also be interesting to know whether the intelligence of the average student-nurse is equal to that of the average public school teacher, for instance, and to what extent, if any, this average intelligence varies among student-nurses in the larger and smaller hospitals. Is there, in general, a high correlation, or correspondence, between low preliminary education and low intelligence among student-nurses? It is possible for candidates of comparatively low intelligence to meet the preliminary educational requirements for admission to training schools? Obviously these are problems of prime importance in a survey of nursing education. Nor is their solution a matter of mere opinion to be pronounced *ex cathedra*.

#### 5.—THE HOSPITAL TRAINING SCHOOL FOR NURSES

The question arises as to how large a hospital should be before it undertakes to maintain a training school for nurses. At what size, if any



definite size—as indicated by the number of beds, number of graduate nurses, range of cases and clinical material, etc.—does the law of diminishing or increasing returns become operative from an economic viewpoint? At what point of magnitude, if any, does the maintenance of a training school for nurses become an economic expedient or alleged economic necessity? The answer to these questions would involve the study of selected groups of hospitals, with and without training schools, located in similar economic areas, supplying practically equivalent qualities of nursing services and with equivalent scales of nursing fees. The study would probably be more reliable if selected hospitals were to experiment over a period of, say, three years, firstly, with the training school, and secondly, over the same period, without the training school. In segregating the cost of the training school (where separate budgeting for the training school has not been done), apart from general nursing services, specific problems in cost accounting would arise. Mere guesswork or general estimates would scarcely be satisfactory. If certain hospitals found it economically advantageous to disband their training schools, more nursing positions would obviously become available for graduate nurses, while, at the same time, certain adjustments might be advisable in the training of prospective student-nurses living in the localities concerned. The whole question of the selection, allocation, and grading of training schools for nurses would also probably emerge at this juncture. The numerous factors to be considered in the studies of cost accounting would involve such matters as the following: — monthly allowances to student-nurses versus salaries paid graduate nurses; number of graduate nurses required to give equivalent nursing care of the patient (could one efficient graduate nurse, for instance, perform the services of several of the average type of student-nurse?); cost of instruction of student-nurses,

e.g. cost of lectures, etc., upkeep of library, classrooms, laboratories, etc., wastage of materials, etc.; relative cost of maintenance (food, nurses' home, etc.); cost of overhead—clerical work, keeping records, supervision, etc.; cost of repairs, depreciation, insurance, etc., etc. Possibly several lay assistants could be trained to do considerable of the menial and clerical work (records, charts, etc.) that would otherwise consume much of the time of the more highly paid graduate nurses. Would the employment of trained lay assistants also relieve the graduate nurse from doing certain duties she might consider *infra dig*? Does the training school tend to improve the general tone and spirit of nursing services? Consider, too, the class of patients who might be attracted and the larger fees available for certain types of nursing services, if the hospital in question had the reputation of engaging only graduate nurses. It might, of course, be necessary to retain the present, or even a lower, scale of fees for the nursing care of the poorer patients. In the case of hospitals employing only graduate nurses should larger grants be available from provincial and municipal sources? On whom should the incidence of the increasing financial support of hospitals fall in any case? Is not the public hospital a national institution as is the public school? Should patients and student-nurses, for instance (assuming that the latter are sometimes regarded as economic assets in hospital maintenance) be expected to pay, directly or indirectly, a proportionally larger share of the cost of hospital maintenance than teachers or pupils should pay of the cost of school maintenance? Does the burden of proof not rest on the person who answers the above question in the affirmative? What better investment than the reasonably generous support of its schools and hospitals can be made by the state?

#### 6.—SOME MISCELLANEOUS MATTERS

The following items may involve some repetition. They are selected

indiscriminately from a preliminary questionnaire prepared by the writer and no attempt has been made here to follow any logical sequence. The purpose of their inclusion is to suggest several types of supplementary problems or subjects that should be considered in a survey of nursing education.

Rate the following factors in the training of student-nurses. Consider the average training school attached to the hospital of e.g. 50 or more beds. (Answer in the light of your observation and experience):—Adequacy of courses (organisation, selection of material, etc., etc.); methods of teaching; adequacy of practical work; adequacy of clinical experience; quality of examinations (written or oral); social life; quality of discipline; standard of admission requirements; standard of graduation requirements; adequacy of time for study; adequacy of time for recreation; care taken of the student-nurses' health; distribution of training (e.g. maternity, surgical, children's diseases, nervous and mental, etc.); responsibility placed on student-nurses, e.g. in bedside nursing, keeping records, charts, etc.; avoidance of over-work or strain; emphasis on, and development of, a high idealism and pride in the nursing profession in its service to humanity; emphasis on general nursing care in the home as well as in the hospital.

In the average training school for nurses (3-year course)—are the teaching methods ordinarily practised sound pedagogically? Is there frequently too much talking (lectures) by the instructor and too little real teaching? Is the size of the classes in many training schools frequently too large for the best teaching procedures? Would the majority of the instructors profit from a course in educational psychology or in modern educational methods? Is time now available (considering the nature of the curriculum and practical duties) for basic elementary courses (20 hours or so for each course) for student-nurses in:—(1) Educational Methods; (2) How to Study Effectively; (3) Psychology

of Abnormal People; (4) Rural and Urban Sociology? Should oral examinations (quizzes) supplement, in greater degree, the usual written examinations set for student-nurses? Do the average written examinations set for student-nurses test memory power to a greater degree than they test reasoning ability? From the viewpoint of efficient training (rather than an economic asset to the hospital) is the average student-nurse on duty too many hours in the day? How many patients can the average student-nurse (e.g. in a maternity ward) efficiently care for? Is the above number frequently exceeded? What are the conditioning factors in the above case? Is a 12-hour period on duty (with duties as ordinarily prescribed and in an average busy season) too long? Would a 10-hour period, under the above conditions, be too long? Is the 8-hour period too long? Would a 6-hour period, considering the time needed for private study, recreation, etc., be too short? Are the principles, or expedients, determining the length of period on continuous duty chiefly:—(1) Of an economic nature; (2) of an educational nature; (3) equally economic and educational; (4) more economic than educational; (5) more educational than economic; (6) chiefly of some other nature?

List the following factors in order of importance in contributing to success as a practising nurse:—industry; character; knowledge; intelligence; tact; personality. List (by letters a, b, c, etc.) the following objectives or aims of education (nursing or general) in what you consider the order (if any special order) of their importance: promotion of health (public and personal); control of the fundamental processes and techniques; worthy membership in the home; citizenship; fitting for a vocation or profession; worthy use of leisure; ethical character. (Consider effect of your answer on type of curriculum).

Does the average private duty nurse in service enjoy the following advantages or opportunities in a fair

degree: reasonable working hours; adequate income; constructive leadership; opportunity for growth (through recreation, study, travel, etc.).

Should private duty nurses give their services on a regular salary basis (monthly or annual or weekly), being paid by or through a responsible registry, while the patient pays the registry (on the instalment basis, if need be) for the amount of skilled nursing service (hourly, or daily, etc.) actually given? Might such a system invite "profiteering" at the expense of nurses or patients?

Which type of nurse experiences the greatest difficulty in obtaining continuous employment—private duty; public health; institutional; practical (may not hold a diploma); special: surgical, maternity, etc., etc.; others? Are the following the chief causes of unemployment—surplus of nurses—through social or other attractions in your community; high nursing fees (by the day or week); inability of available nurses to meet professional or social needs of the family; content of nursing services ill-adapted to meet family or community needs; lack of specialisation in undergraduate training, i.e. surgical, maternity, contagious, etc.; unwillingness of nurses to work in rural or poorer homes where household duties may be added; unwillingness of nurses to work on holidays, etc.; unwillingness of nurses to undertake contagious or very serious cases involving unusual personal responsibility; community unusually healthy, etc.; time on duty too long for average nurse; seasonal fluctuations in demand and supply; other causes, e.g. personal unfitness, lack of tact, etc.?

What effect on nursing education and on the nursing profession in general will probably result from the development of Industrial Nursing Services (e.g. consider the C.P.R., T. Eaton Co., etc., instituting skilled

nursing services for their employees)? What responsibility, if any, should the nursing profession assume towards the whole movement of industrial nursing?

If the number of training schools for nurses should be reduced, on what principle should such reduction be carried out, e.g. restriction by geographical area; restriction to areas on the basis of density of population; restriction on the basis of community needs; advancing of training and graduation requirements, e.g. requirement of more diversified and advanced clinical work; restriction, on the basis of demand and supply, of the number of entrants rather than of the number of training schools; admitting to the Registered Nurse examinations only the graduates of specified training schools; should the regulations governing the accrediting of training schools be provincial (only) in scope; should the above regulations be made Dominion-wide, e.g. through legislation permissive with the various provinces (cf. the Dominion Medical Council Examinations)? Other principles of restriction?

The chief purpose of the present article has been of a two-fold nature: Firstly, to give some indication of the scope and complexity of a survey of nursing education in Canada. This survey is both a challenge and an opportunity—a challenge to promote the interests of the nursing and medical professions and of the public at large and an opportunity to investigate and systematise practically a virgin field of professional study in Canada. Secondly, to enlist the active support and wholehearted co-operation of the nursing and medical professions and of a large group of public-spirited citizens. With this support and co-operation (real and active rather than imaginary and passive) the survey can scarcely fail to attain, in some small measure, the success anticipated by its sponsors—the Canadian Medical and Canadian Nurses Associations.

## Editorials

### *The Nursing Survey*

#### I

This survey, which will have its formal beginning November 1st of this year, when Dr. Weir will begin to put his plans into operation, is the most important single project ever undertaken by the organised profession of Canada. In this important undertaking we have the support and co-operation of the organised medical profession through the Canadian Medical Association. This survey should be a challenge to every nurse in Canada to give her whole-hearted support and also her individual personal help when asked to do so. To bring the survey to a successful completion depends largely on the interest displayed by the nurses themselves. Many will be called upon to give time in preparing information, and when this appeal comes each should realise that time is of outstanding importance. The survey will cover a limited period, and none of that time should be wasted through delayed information.

For the coming four months, could we not adopt the slogan of "Survey First"?

#### II

When we have looked forward for a long time to some undertaking that seems most desirable but almost unapproachable, there is apt to be a large element of unreality about the first days of such an undertaking when it actually materializes. Thus it seems now about our survey, or study, of nursing in Canada. We still ask if this is a Wonderland dream from which Alice will soon awake, or if it can be true that the Director of our study is really at work and that, thus, the study has taken its place among the work-a-day responsibilities of the Canadian Nurses Association. Apparently the latter is the case and, as each member of our Association has much to gain from this work, so

also much help—of many and diverse kinds—is needed from each one.

It is not likely that the study will have much success unless its purposes are clear. Unless the best of understanding can be arrived at in the beginning, and maintained throughout, there is likely to be far more heat than light generated in this undertaking. In order to clear our thought upon this matter of purpose we might approach it from the negative and state as a starting point that this study is not being undertaken merely to collect information with that as an end in itself. No doubt such information if cleverly compiled, would form most entertaining reading matter, and many a tedious hour might be beguiled with it. However, the Canadian Nurses Association has no such beneficent purpose in mind. It is true that information must be collected but only as a means to a further end. And it is this ultimate purpose of the study that must be kept clearly before us. The study must tell us what work is needed by the community from the nursing profession, how the services that nurses have to give can be performed with greatest satisfaction to the community, and how nurses can be best prepared to perform these services.

This last mentioned question of the preparation of nurses for their work is a puzzling one. Many and varied are the solutions to our problem that are offered from the onlooker, perhaps I should say many and brilliant are the solutions, and that they are as varied in form as is the brilliance of the speakers. It takes a saving sense of humour to refrain from despair about ever reaching a solution in the midst of all this variety of advice. However, we may still cling to a determined optimism and refuse to believe that our riddle is entirely unsolvable.

After all it is apparent that the preparation of the nurse for her work must be in terms of the work waiting for her. To quote from a recent



text on a different subject, I would say that, "this remark may sound like a silly truism. It ought to be one; but unfortunately it is not". On the contrary we like to be dogmatic about the teaching of nurses without careful thought concerning the work for which they are being prepared. It is just this latter information that the Study (the time for the capital letter has arrived) should give us a clearer and more forceful fashion than has hitherto appeared. It may show that there is a far greater variety of work included under the one name of nursing than most of us have realised. It may show us that we need a larger vocabulary to name our varieties of work without resulting confusions. It may show us that a variety of different kinds of work brings with it a necessity for greater flexibility in training; that one mold cannot produce different patterns. These and many others are the interesting possibilities. It is idle to speculate and at last to our—as yet, incredulous—joy, it is no longer necessary to speculate. At last we are to have information, instead of opinion, upon which to base our conclusions.

### *Why a Survey?*

In endeavouring to answer this question there are many reasons to be considered, each one of which would seem sufficiently important to warrant a definite attempt to ascertain the facts with a view to the improvement of those conditions which affect that special angle of the problem. It is not possible, however, to separate any one part of this complex situation since the answer and remedy to one difficulty is entirely dependent on all the other phases of the question.

By those who have not given the matter careful thought, the blame for many of the present-day difficulties in the nursing service of any community is often placed on the present-day system of education in the schools of nursing. The time has come when a definite and honest ef-

fort should be made to test the truth and the justice of this criticism by ascertaining definite facts, not only as to the educational system of the schools of nursing, but, perhaps, more enlightening still, why this system has been developed and adopted. We must know the demands made upon the student nurse by the hospital and in what way her education is furthered or retarded by these demands. We must know to what extent hospitals conducting schools of nursing realise their responsibility as educational institutions, the provision they make for proper teaching, the extent to which they are influenced from an economic standpoint, and also what they can conscientiously offer in the way of teaching and experience to the prospective student. We must know the type of service demanded from the student nurse by the medical profession. Is proficiency in bedside nursing of the patient considered sufficient or is the student nurse expected to add to this the knowledge and ability to not only perform many duties formerly done by the medical profession but to add to those the rapidly increasing number of special tasks which go hand-in-hand with the advance of medical science and practice.

In short, we must know what type of service is demanded of the nurse of today by the hospital, the medical profession and the public, and to what extent and in what way the nursing profession should endeavour to prepare its members to meet these demands.

In answer to that we must go far afield. We cannot limit our knowledge to the hospital walls, but must look beyond them into the life of the community. In doing that we find ourselves confronted with many difficult problems. Some of these we may never entirely solve, but in the solution of any, we are firmly convinced that we will need the intelligent interest and the whole-hearted

and understanding co-operation of all members of the community.

The answer as to why we plan a survey of nursing in Canada is to place all the facts on the table and from this definite knowledge to begin at least to develop and to build a different structure which will not only serve our generation but whose foundations will be so well and wisely laid that future generations of nurses may add, as time goes on, such additions as their day and generation require.

We would also hope to find some solution to the economic difficulties presented when an adequate nursing service for all members of society is considered, or, if not to find an actual solution to at least have the facts realised, understood and definitely separated in the public mind and not confused, as at present, with the question of nursing education and nursing service.

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### *An Objective in Membership*

For two years a special committee appointed by the Executive of the Canadian Nurses Association has studied the matter of dual affiliation in our national organisation. Such a study was necessitated by the fact that in six provinces nurses hold membership in the Canadian Nurses Association through organisations other than provincial, that is in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec. In those provinces, notably the latter two, nurses belonging to certain organisations affiliated with the national association may hold membership in the Canadian Nurses Association and the International Council of Nurses without belonging to their provincial association.

Those actively engaged in increasing provincial membership are aware of the handicap entailed by such a policy. Many who value membership in the national organisation and affiliation with the International Coun-

cil of Nurses fail to belong to their provincial association, since national and international affiliation may be secured apart from provincial membership. By the same token, many nurses holding provincial membership are forced to pay a dual affiliation fee, that is when the alumnae to which they belong happens to have national affiliation.

The last biennial meeting of the Canadian Nurses Association agreed that membership through provincial associations only should be the objective of the organisation, and that the putting into operation of such a plan be delayed until its further consideration at the next biennial meeting to be held in Regina in 1930.

The committee has secured certain data, the study of which is both surprising and convincing. In 1928, 57% of the total membership in the Canadian Nurses Association was composed of provincial associations and 43% of organisations other than provincial. Forty associations, then, other than provincial, in six provinces, are affiliated with the national association and compose 43% of its present membership. An effort has been made to learn from those organisations how many of their members are eligible for membership in a provincial association. From replies received it is estimated that eligibility is confined to 62%. It is axiomatic that the price paid for provincial affiliation only will probably entail some increase in our national affiliation fee.

In the opinion of those studying the question, provincial affiliation only is the logical form of organisation and, to facilitate the sound growth of those associations, should be adopted at the earliest opportunity. Meanwhile, each provincial organisation should devote its energies to securing increased membership and thus aid in the fulfilment of the objective of the Canadian Nurses Association—membership through provincial associations only.

## *Breast Feeding in Health Centres*

By A. B. CHANDLER, M.D., Medical Director, Child Welfare Association, Montreal, P.Q.

During the last few years much has been written describing the orthodox modes of caring for the young infant's nutrition. There appears to be only one point on which all agree, namely, that mother's milk is the ideal food for all babies and the suitable food for prematures and certain sick infants. There have been many arguments as to the proper time for first putting the child to the breast, as to the frequency of nursing, as to the diet of the mother, but no one has claimed to produce as good a food in any laboratory as the human breast is accustomed to secrete. This fact has been aptly expressed by Oliver Wendell Holmes—"A pair of substantial mammary glands have the advantage over the two hemispheres of the most learned professor's brain in the art of compounding a nutritive fluid for infants."

The popularity of nursing in spite of this well known fact seems to be running in cycles. It was the only method of feeding until the second half of the last century saw the widespread introduction of baby foods which had a huge sale owing to the extensive advertising they received. At the beginning of this century the propaganda of the various agencies interested in child welfare began to have its effect, and for twenty years breast feeding was steadily on the increase and the use of baby foods all but vanished. During the last few years, however, the pendulum seems to be swinging the other way and apparently less breast feeding is being done at the present time than there was ten years ago. There are several factors that seem to be at work to bring this about.

Is there any connection with the rise in popularity of pediatrics as a specialty during this period and an

apparent decline in nursing? When the obstetrician hands the baby over to the pediatricist does he not imply that he is not familiar with modern methods of artificial feeding rather than not being conversant with breast feeding? If that is the case, has the pediatricist been forced to make good by living up to this implication? Is not the keen competition in pediatrics having a tendency to make us show our skill in artificial feeding rather than keeping a baby on the breast, which is less spectacular and much more difficult? Both the medical student and the graduate interested in children devotes almost his whole time to the artificial feeding of children and little or none to the difficulties of breast feeding.

There are many factors in modern life that are conducive to bottle feeding. The future mother has been reared in an atmosphere of excitement. She has gone to work at an early age in domestic service, factory or office. Home life has largely disappeared so that the home is not much more than a place to sleep and to store her scanty wardrobe. Pleasures are all taken outside the home, at the movie, dance-hall or in the automobile. The girl is a pal before marriage and she is carefully taught she must be so afterwards if she is to retain her husband. One cannot stretch one's imagination to visualise a mother nursing her baby as a pal any more than to associate her training as satisfactory to produce the phlegmatic type of woman who makes the ideal mother for nursing.

Modern housing conditions are not conducive to breast feeding. The young couple must take quarters in a crowded section whether in a boarding-house, a one-roomed apartment or, if in a larger place, generally in a poorly constructed building where one can hear any noises from

(A paper read at the Canadian Society for Diseases of Children Meeting, Hamilton, Ont., May, 1929.)

the neighbouring apartments. In such quarters it is difficult to correct a breast feeding problem when the mother and physician both know that it is easier to give a bottle than to attempt to increase the amount of breast milk by stimulation from a hungry baby.

The very emphasis we have put on the baby-scale is working to our disadvantage, as the mother knows that her baby should gain regularly. She is upset if the neighbour's baby on a bottle's gain is more regular and with far less trouble to her and more sleep to the father.

The work on nutritional disorders which has led to the almost universal giving of cod liver oil and orange juice has probably worked to the advantage of the bottle-fed baby much more than we realise. We can no longer claim that the bottle-fed child is almost sure to develop rickets—in fact, we know that cod liver oil will protect him, even in this climate, from any but the mildest manifestations, and that the breast-fed baby is equally entitled to his daily doses of this food. The threat of the child developing summer diarrhoea, if weaned, is no longer much to be feared because the knowledge is widespread that if the bottle-fed baby is well cared for there is little to be feared from this disease which used to be so common and so fatal. We do not often see nowadays figures showing that the bottle-fed baby stands five times as great a chance of dying as the breast-fed child does. This, of course, is still true if both children are neglected.

With these thoughts in mind the Child Welfare Association decided to make a survey of its work in breast feeding, neither with the idea of answering the question whether health centres were aiding bottle feeding nor with the idea of showing that the breast feeding work was adequate. Some of the findings were of sufficient interest to publish them in hopes that others may be stimu-

lated to furnish similar figures. There have been few statistics published recently in this connection and these have nearly always been with a definite idea of proving that breast feeding was adequate. Our figures are shown just to represent the state of affairs in this locality, and my personal opinion is that similar findings are present generally throughout the continent. It is hardly necessary to say that I am disappointed to have my suspicions that there was not an adequate amount of breast feeding being done, thoroughly substantiated.

It is almost impossible to produce records as to whether breast feeding is declining or not. Records from private practice are of little value as so much depends on the type of practice. One paediatrist might have a preponderance of cases referred to him from birth while another might receive largely difficult cases already in trouble. Their records would not give any indication of the average in the community. Chart I—Shows a comparison between a sampling of our figures taken in 1928 and a similar group of Toronto figures published by Brown in 1917. Both were worked out in the same way. The results are almost identical with a shade in favour of the Montreal figures. It would be interesting to see what the Toronto figures of today would show.

Chart II—Was made to answer the question I have often heard asked—"Do health centres favour weaning?" These figures do not correspond to the ones in Chart I because they were taken from the nurses' report of 1927. The previous figures are better, I think, because they were taken as part of the Breast Feeding Survey and were possibly influenced by it. The information in Chart II was taken with nobody's knowledge and I think probably favours the bottle-fed baby. Health centre babies from this chart would seem to be nursed longer than similar babies who came to the health centre after



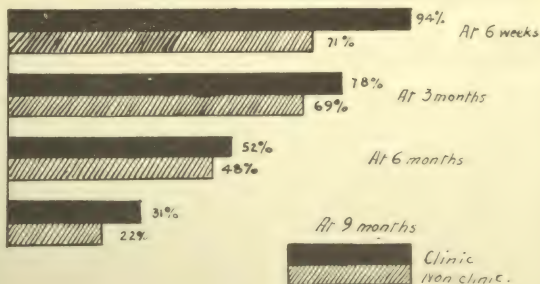
COMPARISON IN LENGTH OF BREAST FEEDING.  
OF  
TORONTO HEALTH CENTRE CASES IN 1917  
WITH  
MONTREAL HEALTH CENTRE CASES IN 1928

CITY	No. of CASES	PERCENTAGE OF NURSING UP TO			% of NURSING OVER 9 Mos.
		3 Mos.	6 Mos.	9 Mos.	
TORONTO 1917	946	79.65	60.51	31.88	
MONTREAL 1928	769	79.98	66.06	33.95	13.93

C.W.A. Montreal  
1928

No. 1

BREAST FED BABIES  
STUDY OF LENGTH OF TIME OF BREAST FEEDING  
CLINIC & NON-CLINIC BABIES.



C.W.A. Montreal  
1928

No. 2

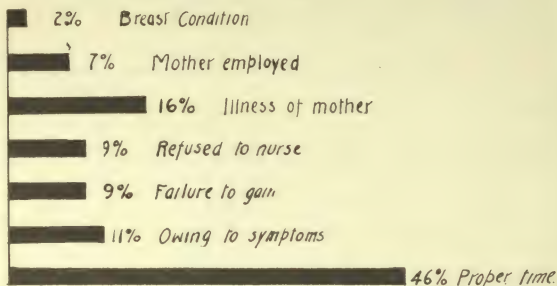
weaning. The same class is represented in the two groups—the only difference being that one class was weaned after registration, while the non-clinic babies were weaned before arrival at the centre.

#### REASONS FOR WEANING

It was considered important in making this survey of 530 babies weaned when under the care of the Association to find out why artificial feeding was necessary. Chart III is

indicates either that the time we have chosen is wrong, or that breast feeding is totally inadequate amongst our babies. The arbitrary time chosen when weaning may be inaugurated was left entirely to the physician in charge of the centre. The Association has never deemed it wise to put down an arbitrary time for weaning, leaving it to the discretion of the physician when weaning should take place after six months. Personally I

### REASONS FOR WEANING.



No. 3

C.W.A. Montreal  
1928

made out to show this. It was decided that "my milk was no good" would not be accepted as an answer, so the headings enumerated were decided on. These are given for what they are worth as the mother's story of the difficulty. Taking these up in detail we notice that some of them seem unduly high while others are lower than would be expected. Theoretically all babies should be weaned at the proper time, so that our findings of 46 per cent. weaned at this time is less than half what it should be and

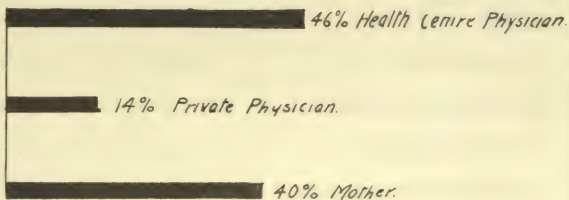
am in favour of a gradual cessation of breast feeding extending over six weeks by dropping one nursing a week.

The high percentage of seven weaned owing to the mother going to work is partly an indication of the low economic level of the class looked after by the Association and partly owing to our having to have some definition of when a baby is breast fed. Surveys of this kind are almost universally vague on the latter point. When a mother was away from the

baby working all day it was considered that her baby was getting a negligible quantity of breast milk. So these babies as well as the ones who only nursed at night were considered as weaned. Owing to this limitation, in what might be termed the partially breast-fed baby, it is difficult to compare our figures with others. The number of children nursed only at night by the clinic class of mother is considerable.

a physician is indicated elsewhere. We have made a rather arbitrary division between "Refusal to Nurse," "Failure to Gain" and "Owing to Symptoms." They all occupy a similar place as to rate of frequency and I think the distinction is worth while as it puts the gastro-intestinal symptoms in about their proper place and upholds the public health claim that breast milk is almost invariably good in quality, but may be very poor in

### RESPONSIBILITY FOR WEANING.



Total Number 524

No. 4

C. W. A. Montreal  
1928

Illness in the mother accounting for 16 per cent. of the weaning of these babies is certainly not a true picture of the case. The high percentage is no doubt partially due to her reaction to questioning, but also accounts for a considerable proportion of the cases where the weaning was done by the mother herself owing to her being discouraged at the progress of her baby, or perhaps she was simply taking what she thought was the easiest path. How many of these cases were done at the suggestion of

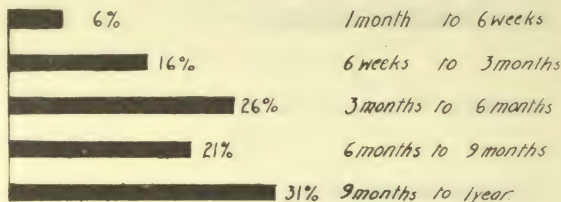
quantity, accounting for many babies refusing to nurse an empty breast or failing to make an adequate gain when the quantity is limited.

We were not only anxious to find the reason for weaning but also wanted to place the responsibility for this change in the babies' food. Our findings in this regard are shown in Chart IV. Has this weaning been done by the health centre physician, the private physician or the mother? I feel there is a definite lead in this chart pointing the way to what was

largely in our mind when the survey was undertaken. When 40 per cent. of these children were weaned by the mother I feel convinced that complementary and supplemental feedings were being freely given or she would never dare make this change. What she did was to gradually increase these feedings without advice. The lessening of the demand on the breast made weaning of course inevitable. The relation between complementary

it indicates only a minimum of sickness amongst the children who were getting health centre care. While at times the private physician seems to his confrere in the health centre to wean for insufficient reason it must always be remembered that he generally has not the knowledge of the home conditions available at the health centre through the efforts of the public health nurse. No doubt also the private physician frequently takes

### WEANING AGE OF REGISTERED BABIES.



Total No. 530

C. W. A. Montreal  
1928

No. 5

and supplemental feedings, and weaning is being further studied but the cases are still too few to be able to draw definite conclusions. There is no doubt, though, that giving generous artificial feedings allows a mother to wean her baby without further advice from the physician.

The small number of babies weaned by the private physician, I feel, is all to his credit, although it must be recognised that the economic level of most of the parents precluded many private consultations. Perhaps also

the view that the health centre can adequately look after the baby, so his main endeavour is to reconstruct the mother.

Chart V shows the age of weaning as brought about by the health centre. These infants all came to us at least partially breast fed so the responsibility must rest largely on the Association. The previous figures quoted as to the large number of mothers going to work and the large number who were below par in health certainly would necessitate early supple-



mental and complemental feeding. The conditions of modern life, including habits of living acquired by the girls many years before marriage, would indicate the early falling off in ability to nurse in spite of the care and teaching given at the health centres. No doubt the mingling of the mothers at the health centre and the apparently excellent results achieved with the bottle fed-baby have an important bearing in discouraging the

important. Breast feeding, if normal, is easy and requires little effort or time on the physician's part. If difficult it requires much more effort and greater skill than devising a suitable formula. So it comes down quite largely to a matter of effort on his part and the time he can devote to urging the mother to keep on nursing. With an attendance of from thirty to ninety mothers at a conference little time can be given to any

PERCENTAGE FEEDING OF 2875 BABIES WHEN  
REFERRED TO THE CHILD WELFARE ASSOCIATION IN 1928

Feeding	1m	2m	3m	4m	5m	6m	7m	8m	8m to 1yr.	1yr to 2yrs.	Total
Breast	71	64	46	41	29	39	36	31	16	3.5	54
Artificial	18	23	41	46	61	51	52	40	24	1	26
Mixed	11	13	13	13	10	9	7	19	8	2	11
General						1	5	10	52	93.5	9

C.W.A. Montreal  
1928

No. 6

mother who is having a hard time to feed her baby naturally. To obviate this we established two years ago a separate clinic just for breast-fed babies. It was carefully explained to the mothers that they were on the honour roll as long as they nursed their babies, and would have to go to the general clinic when weaning was necessary. The results from this type of clinic are not at all convincing that the extra expense is justified.

The part the health centre physician takes in the weaning is very

one case, so much of the teaching must be done by the nurse. As a general rule she is much more enthusiastic about breast feeding than the physician, and to her energy is due much of the success of the centre in this type of feeding. By her zeal she has frequently to make up for a lack of effort on the physician's part.

Glancing at the figures in Chart V one is struck by the fact that only approximately one-third might be termed easy breast feeding cases. These are the ones weaned after nine

months. Nearly one-half of the weaning was done between three and nine months. This period would include a large number of cases where the mothers' health failed, also a great many weaned by the mother herself following generous supplemental and complemental feedings.

Weaning during the first three months was far too general as the babies weaned before registration are not included in this group. I feel that with a larger staff and less crowded conferences many of these babies could have been kept at the breast.

Chart VI shows the feeding of the babies when they are first referred to us. These include cases referred by maternity hospitals, social agencies, private physicians and the ones who come of their own accord. It will be seen that of the infants under one month, already twenty-nine per cent. are partially or entirely artificially fed. In this number are included all those babies where breast feeding has been unsatisfactory either owing to the late arrival of breast milk or where strenuous attempts were made to bring the baby back to his birth weight in the first two weeks of life. There is also a large number where the breast milk is lessened in quantity when the mother returns home or when she starts about her usual duties in the home again. If the mother had been suitably warned of this possibility they could be helped over this difficult period without artificially feeding the baby.

The figures in Chart VI are very illuminating to show how steadily and rapidly the number of artificially-fed babies rise. At three months 41 per cent. were entirely on the bottle, and so on down the list till we come to between six and nine months old babies. These came to us to be weaned, having been looked after by the mother with little or no assistance.

These are, however, but a small proportion of the total number and were well through the dangerous age as regards the saving of life.

Comparing the figures on this chart with the weaning done by our health centres one is justified in concluding that while the health centre figures have much to be desired yet they show their value as compared with the breast feeding done outside amongst this class of mother. It has always been the case that the well-to-do nurse less than those from the lower economic levels so it can be presumed that the amount of babies on artificial foods in private practice is considerably higher.

#### CONCLUSIONS

Modern life with its housing conditions, its fast pace and the training of the rising generation is not conducive to breast feeding.

There is less breast feeding outside the health centres than there is in them amongst the same class of mothers.

Lack of health of the mother seems to be a very important factor in her inability to nurse.

A large proportion of the weaning is done by the mother owing to her baby having been given complemental and supplemental feedings.

Too many babies are given artificial feedings at an early age before coming to the health centres. Maternity hospitals and private physicians are not free from blame for lack of proper teaching of mothers in regard to breast feeding.

The training of medical students and pediatricists must include more attention to breast feeding.

The work of the pediatricist in the Maternity Hospital must include not only the care of the child but also the education of the mother in breast feeding.

Reference: Alan Brown, *Journal of Canadian Medical Association*, March, 1917.

## *Care of Post Poliomyelitis Patients*

By GLADYS E. SMILEY, Superintendent of Nurses, Provincial Special Hospital, Edmonton, Alta.

The Provincial Special Hospital, established by the Government of the Province of Alberta to treat patients suffering from the after effects of poliomyelitis, was officially opened on January 28th, 1928, with a capacity of sixty beds, fifteen of which are cots.

The building is a one and a half storey frame structure of U shape facing south. Wide verandahs are provided which are capable of holding all the beds in the wards. On January 31st the Hospital was opened for the admission of patients, and to date one hundred and thirty-three patients have been admitted.

In connection with the institution an Out-Patient Department is operated in which ninety-eight patients have been admitted for examination and seven hundred and ninety-six for treatment. Clinics are held thrice weekly, Tuesday, Thursday and Friday afternoons.

The nursing care is carried out by graduate nurses assisted by Ward Aids, these latter being an innovation as far as Edmonton is concerned, with most satisfactory results. According to public health regulations patients with poliomyelitis are considered infectious for three weeks, and are therefore treated at the Isolation Hospital or in their homes. Upon admission to this Hospital all patients are treated as bed patients, thus securing the factors most to be desired in the early after treatment: rest and prevention of deformity. This is obtained by means of Bradford frames, plaster jackets and splints, hot packs and radiant heat—these latter treatments being found most helpful in relieving muscle tenderness.

In the nursing care special attention is given to patients who are on frames and in casts or whose nutrition is poor so as to avoid pressure sores.

Another factor of which all ad-

vantage is taken is fresh air and sunlight—so abundant in Alberta—and daily until the weather is too severe the children spend most of their waking hours on the verandahs with as little clothing on as is necessary for comfort. The glare of the sun is overcome by use of goggles and eye shades, and the beds are covered with brown spreads.

When the muscle tenderness is gone gentle massage along with muscle re-education under the direction of the medical superintendent is begun and carried out by trained masseuses. Since the beginning eleven thousand five hundred and thirty-five treatments have been given. Complete muscle tests are made about every three months, so that the progress of the patient may be noted.

Upon discharge the patient is given the necessary instructions and requested to report back in about four months. At that time if further treatment is indicated or apparatus needs renovation, the patient is readmitted until this work is completed.

The Department of Health, while being most anxious to help these patients physically, has not overlooked the necessity of giving the children a chance to take their place in the world on recovery, and to assist in this end a full time school teacher is employed so that the children may carry on their regular school work without interruption. The patients are arranged in their beds according to their grading in school which facilitates the work of the teacher, and under such methods the pupil receives individual attention and progress is favourable.

Various organisations have shown in a practical way their desire to help the work of this Institution, and donations have been received that have added considerably to the enjoyment of the patients.



LIBRARY, WINNIPEG GENERAL HOSPITAL



## *The Nurses' Library, General Hospital, Winnipeg*

By RACHEL NIGHTINGALE FOGARTY, Librarian

In the year 1919, Mrs. W. H. Gardner made a gift of \$2,000.00 to establish a Nurses' Library in memory of her two sons, Stuart and Harry Robertson, who were killed in action in the Great War. Owing to structural difficulties it was impossible to release suitable space until 1927, when the former reception rooms in the centre section of the Nurses' Home were remodelled for this purpose and the library was opened in November of that year.

The room is quiet at all times. Soft Wilton rugs, subdued effects of golden brown woodwork and book-cases, lend themselves to peace and concentration. Well-chosen pictures on buff walls, "The Venus of Milo," "The Nike of Samothrace," and an etching of the "Nurses' Memorial at Ottawa," pretty cretonne hangings and cushions, cozy window seats, and reading lamps which create a soft and diffused light, make a most comfortable and irresistible room.

In all there are five hundred or more book; all pertaining to the nursing profession; most of them for reference only. These may not be

taken from the room during library hours; others may be borrowed for a given time, and renewed at the discretion of the librarian. The majority are of recent publication and latest date. They all have been carefully chosen to cover the subject thoroughly and completely, and to be of the greatest use to instructors and students who come at all times for information on anything connected with the profession of nursing.

Special tables are assigned to magazines and nursing journals, and at a table near the door are placed notices of new books, current happenings and special events in history, as the dates occur.

For the past year, the library has also been used fortnightly for lectures by various speakers on such subjects as, "Canadian Authors," "Women in Politics," "Current Events," etc. These lectures have been tremendously enjoyed and appreciated, being most interesting and helpful.

The library is open daily from 8 a.m. to 10 p.m., with a librarian in charge.

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## *American Nurses' Association*

An Historical Sketch of the American Nurses Association, prepared by Virginia McCormick, has recently been published in attractive form.

This brief outline of the development of nursing in the United States records excellently the growth of organisation work, based chiefly on the fact that nurses early recognised the need for a national organisation which would protect and aid in developing nursing and nursing standards.

The numerous activities which have been undertaken for these purposes are concisely described, while several pages are devoted to a de-

scription of the Association as the official national organisation and its relationship to other nurse groups and to the individual nurse.

In the foreword it is explained that while the sketch has been compiled from material already at hand, "it is hoped, before many years, to prepare a comprehensive history of the American Nurses Association through the study of original documents and with the assistance of those members whose memory reaches back to the early days of nursing in the United States." The publication of the sketch augurs well for this greater enterprise.

## *Miss Ethel Johns*

Miss Ethel Johns, recently appointed director of studies of the Committee on Nursing Organisation of the New York Hospital, is one of the best known of the Canadian nurses. Born in England and educated at Howell's School, Denbigh,



MISS ETHEL JOHNS

North Wales, Miss Johns is a graduate of the School for Nurses, Winnipeg General Hospital, Winnipeg, Manitoba. Following graduation she spent one year of study in the Department of Nursing Education at Teachers' College, Columbia University.

Miss Johns held the following executive positions in Canada previous to her appointment in 1925 to the Paris office of the Rockefeller

Foundation: Superintendent, McKellar General Hospital, Fort William, two years; superintendent, Children's Hospital, Winnipeg, four years; director of nursing, Vancouver General Hospital, Vancouver, three years, during which time she also was assistant professor, Department of Nursing and Health, University of British Columbia, and established the five-year degree course at this university. Miss Johns remained for five years altogether in this latter position, following which she was attached for four years to the Rockefeller Foundation. Previous to going to Paris in 1925, she made a study of the status of negro women in nursing in the United States. During Miss Johns' time in Europe she assisted with the development of nursing services in Hungary and Roumania.

While in Winnipeg Miss Johns was a member of the Manitoba Government Public Welfare Commission for four years, during which time the commission accomplished a tremendous amount of work for the development and improvement of public welfare. It has been reported that the commission valued highly the assistance rendered by Miss Johns in all its discussions, study and decisions.

Miss Johns has a very special interest in the Canadian Nurses Association as she served from 1917-1920 as secretary of the organisation, at a time before a National Office was established and an executive secretary appointed. Miss Johns has always been deeply interested in the Association and in *The Canadian Nurse*, to which she has contributed valuable material from time to time.

## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,  
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

### *A Gift to Nursing Education*

A very wonderful gift to nursing education in Canada has been made through the generosity and interest of the late Mr. Harry Judson Crowe, of Toronto. In the will of the late Mr. Crowe is found the following statement:—

“It having fallen to my lot to spend certain periods of time as a hospital patient, I have had opportunities of noting the unselfish and invaluable service rendered by the women nurses in general public hospitals. Their duties are extremely arduous and allow them very little leisure, with the result that at the end of three years’ training in their chosen profession they are often weakened physically and practically destitute of funds, and to be compelled to commence their professional work under such conditions would prevent them from doing full justice to themselves or their patients. The nature of her profession not only in saving life but in the opportunities which it affords for exerting a far-reaching influence for good, places a nurse in a position of singular importance in a community. I therefore feel that it is desirable that the nursing profession should receive greater recognition and encouragement, and with this object in view I desire that the said one other of said three shares of my residuary estate shall be held by my trustees as follows.”

The bequest is to take the form of annual scholarships to the value of six hundred dollars each for an approximate period of ten years, these scholarships being awarded to a graduate from the largest public interdenominational hospital, in the largest city by way of population of each of the provinces of Canada, and also the Dominion of Newfoundland. In Ontario the Toronto General Hospital is the designated hospital, and

in Nova Scotia the Victoria General Hospital of Halifax. It is further stated that this last mentioned hospital should receive each year double the number of scholarships awarded to any of the other hospitals in other provinces. This special provision was made as the city of Halifax was the native city of the late Mr. Crowe.

The object of these scholarships is to assist or enable the beneficiary selected to take a post-graduate course for one year in a Canadian university, to be chosen by the beneficiary.

While the approximate time of ten years is stated the gift may even exceed this amount, as provision is made to continue until the surplus capital or income shall be entirely exhausted.

To have these generous scholarships available for every province in Canada is like having an oft-repeated dream come true. It is impossible to ever begin to estimate the effect this generous gift will have on the development of nursing education. When we realise that in the next ten years approximately one hundred and ten nurses will have the opportunity of receiving special preparation for their special branches of work, we only begin to glimpse what this benefaction means. Already we are beginning to reap the benefit as this fall term finds these first scholarship students enrolled in the different universities of Canada.

In the opening paragraphs it was stated that the late Mr. Crowe wished the nursing profession to receive recognition and encouragement, and judging from the appreciation expressed not only by the direct beneficiaries of this year, but by all members of the nursing profession, it would seem that already this feeling of encouragement is widespread from the Atlantic to the Pacific.

## Concerning Co-operation

By S. PERSIS DARRACH, Reg.N., Brandon, Man.

May I submit a few vagrant thoughts which have crystallised into a definite impression since attending a recent convention held jointly by the Manitoba Hospitals, Medical and Nurses' Associations.

The problem of adequate provision for the care of the sick and the education of the nurse continues to be an unsolved problem of perennial bloom, and must continue to be so, in the great march of progress.

But would we not arrive more quickly at certain obviously logical conclusions if a greater degree of understanding and unanimity existed between the three groups who are labouring for the care and healing of the sick, i.e., hospital trustees, doctors and nurses?

I have intentionally placed the group in this order. Hospital Boards first, because, too often, it seems, doctors and nurses are inclined to stress the professional aspect first. This is no doubt natural: we are taught to regard the patient and his welfare as our special responsibility.

But before the patient can have hospital care, or the surgeon his operating room, or the nurse her education, we must have hospitals, and we must have Boards of Trustees to erect, equip and maintain them.

Having done their best to meet estimated requirements to the utmost of their ability and resources, in a short space of time we calmly return, like Oliver Twist, asking for *more*: *more* equipment, *more* accommodation and *more* education. Is it to be wondered at that our requests are not always met with enthusiasm, but rather with indifference or opposition, and are we not sometimes prone to critical thoughts of "exploiting the nurse," etc., before we have patiently ascertained whether their failure to understand certain (to us) self-evident facts is not the result of our failure to adequately interpret them?

We like to think that as a profession we are actuated by altruistic motives,

secondarily we gain our livelihood thereby.

Members of Hospital Boards undertake a heavy financial responsibility solely for the service of humanity, and men (or women), who are altruistic enough to voluntarily undertake service of this type will usually be found neither unable nor unwilling to understand and co-operate, to serve the best interests of the patient if we enlighten them as to the reason why certain things are required.

Illness is recognised as a community problem and an economic problem, not a professional problem. Yet how often do we insult the intelligence of the community representatives by the meagre information vouchsafed them, whereas, full confidence and an enlightened understanding would enlist their co-operation often to the fullest extent.

We must give our problems more publicity if we are to be supported by public opinion. True, it must be wise publicity.

If all nurses who graduate from our nursing schools had a greater appreciation of the effort required for the maintenance of a hospital and nursing school, they might become valuable publicists for the achievements and requirements of their alma mater. Instead, too often they assume the creditor instead of debtor attitude towards their school.

I am one of the humblest members of a Hospital Aid Society since learning that the convener of one committee was responsible for soliciting and collecting one hundred cakes per day for five days when catering at the annual exhibition. Linen purchased for the hospital at the expense of so much energy is indeed to be regarded and treated as a valuable commodity.

A vastly informed public opinion has taken the place of that existing a few years ago. Popular magazines now retail information scarcely known to the profession ten years ago, and we



must provide more than a few elementary facts if we are to be supported in our attempts to cope with scientific requirements of our day. To that end, may I urge a greater appreciation of the contribution made by Hospital

Boards and their potential value as one of the most important factors in advancing a cause which requires the combined wisdom and experience of all groups who are labouring in the interests of the sick.

### *New Medical Centre*

An arrangement has been made whereby the New York Hospital and several other New York institutions will unite with the Medical School of Cornell University to form a central institution which will house not only a thousand-bed hospital offering all services, but the Medical School and the School of Nursing as well. This new centre is being built on the East River between 68th and 70th Streets, adjoining the Rockefeller Institute. The buildings will be of the "tower" type and are an interesting example of the new architecture. In connection with this project the Nurses' Alumnae Association of the New York Hospital has formed a committee from among their members. The chairman is Miss Mary Beard, of the Rockefeller Foundation, and the membership includes Dean Goodrich, of the Yale School of Nursing; Miss M. Jordan, superintendent of nurses of the New York Hospital; Miss Anna Reutinger, superintendent of St. Mary's Hospital for Children; and Miss Lydia Anderson, instructor of nurses. This committee has appointed Miss Ethel Johns director of studies, and for a two-year period she will assist in formulating plans for nursing administra-

tion and education for submission to the authorities of the new enterprise, of which Dr. Canby Robinson, dean of the Medical School of Cornell University, is the head. The committee has been fortunate in securing the following women to act in an advisory capacity: Miss Mary Roberts, editor, American Journal of Nursing; Miss Katherine Tucker, director of the National Organisation for Public Health Nursing; Miss Nina Gage, executive secretary of the National League of Nursing Education; Miss Mary Marvin, instructor in Nursing Education, Teachers' College; Dr. May Ayres Burgess, director, Committee on Grading of Nursing Schools.

This is the first time that a nurses' alumnae association has obtained the privilege of being recognised officially in a consulting capacity in the early stages of an enterprise of this character. Its president, Miss Mary Beard, and her associates are to be congratulated on the foresight and courage which has made this new departure possible, and the medical men and business administrators responsible for the project are to be commended for their broad-mindedness in granting nurses this privilege.

### *Scholarships Awarded*

In accordance with its policy of granting scholarships for a year's work in Public Health Nursing at Canadian Universities, to a limited number of well qualified graduate nurses the Central Board of the Victorian Order of Nurses for Canada announces the following awards for 1929-30:

Miss Fern Barker, Bancroft, On-

tario; Miss Lillie Clarke, Montreal, Quebec; Miss Alberta Creasor, Hamilton, Ontario; Miss Marjorie Fleming, Calgary, Alberta; Miss Miriam Michell, Elmwood, Ontario; Miss Miriam Mercer, Montreal, Quebec; Miss Laura Spearing, Brantford, Ontario; Miss Christian Shand, St. John, New Brunswick.

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### County Health Unit—England

By RUBY M. HAMILTON, Director of Field Nursing, Ontario Division,  
Canadian Red Cross Society

To draw a word picture of the County Health Scheme in England is rather difficult as no two counties are organised in exactly the same way.

Before attempting to describe in detail the health work of any county, it may be interesting to look back over a few of the historical events that led up to and influenced the system now in vogue.

The plague in the reign of Charles II, followed by the Great Fire in London, led to the first Housing Act, which laid down the width of streets and height of houses, but did not prevent refuse from being thrown into the streets. Unsanitary conditions continued to exist, and in the latter part of the eighteenth century, following Jenner's discovery of vaccine, which so greatly reduced the number of smallpox cases, a period of scientific and sanitary awakening began to develop. The industrial revolution produced overcrowding, and appalling conditions ensued. Organised water supplies and proper drainage were practically unknown.

In 1831 the cholera epidemic stimulated further effort to improve sanitation, and the first Board of Health was formed with local boards to investigate conditions.

In 1837 began the present system of birth and death registration, and at this period public opinion was aroused over a report which showed that women and children were employed in night work and children under nine years of age worked in factories on twelve-hour shifts.

Various Acts dealing with specific conditions were passed during these

years, and in 1848 the first Public Health Act gave local authorities greater power, and a Central Board of Health was formed. Chadwick, as a member of the board, stated that money spent on sanitation would reduce poor law expenses, but the board met with strong opposition from private individuals, vested interests and political sources, and on the resignation of the members of the board, *The Times* comment was, "We prefer to take our chance of cholera and the rest, rather than be bullied into health."

It was not until 1875 that the great Public Health Act was passed, and it is still in force.

#### THE MINISTRY OF HEALTH

Today the Ministry of Health is the central health authority responsible for carrying out this act.

All measures in connection with the health of the people, including prevention and cure of disease; treatment of mental and physical defects; care of the blind; research work; publication of information and statistics and the training of persons for health services become the duty of the Minister. The local authority is the County Council, and this is an independent unit within the county responsible directly to the Ministry of Health. The public health duties of the council are: Supervision of all other authorities in the county; appointment of a medical officer of health; making of bylaws and administration of: Isolation Hospital Act, Housing Act, Education Act, Maternity and Child Welfare Act, Midwives Act, Mental Deficiency Act, etc., etc.

From this, one can see the responsible position of the county medical officer of health, the care with which

he must be chosen, the preparation he requires and the support he must be given by the public.

#### WARWICKSHIRE

While in England I had the privilege of seeing the county health work in Surrey, West Sussex, Warwick, Gloucester and Isle of Wight. Of these I have chosen Warwickshire as being fairly typical of county health work as it is carried on in England today. Warwickshire is situated in the Midlands, the southern part of which is a beautiful agricultural country and the northern part largely mining and industrial. It has an area of 860 square miles and a population of 370,600. The medical officer of health is also school medical officer and is responsible for the health of the entire county with the exception of the city of Birmingham, which has an independent County Borough Council. He has his headquarters in the county town of Warwick, which is centrally situated.

#### STAFF PERSONNEL

The medical staff consists of: 1 medical officer of health, 5 full time assistant medical officers of health, 5 part time assistant medical officers of health and 4 dental surgeons.

The health visiting staff or public health nursing staff, as the term more familiar to us, is composed of: 1 superintendent, 1 assistant superintendent and 15 health visitors.

It is rather interesting to know that Warwick was the first county in England to appoint a full-time health visitor in 1907 and that she still remains as the superintendent of Health Visitors and Inspector of Midwives.

#### DISTRICTS

The county is divided into fifteen districts, according to population, and one health visitor is allotted to each district. The question of transportation in a county in England presents an entirely different problem to that of a county in Ontario. Practically all roads are excellent; busses and trams connect all towns and villages, and trains run every

twenty or thirty minutes. The county superintendent usually has a car and the health visitors have bicycles.

#### HEALTH VISITOR

The duties of the health visitor consist of general public health work of an educational nature, including infant welfare and pre-school visiting, school nursing and tuberculosis visiting, attendance at child welfare, ante-natal, tuberculosis and orthopedic clinics. It is very gratifying to the nurses of England to realise that since April 1st, 1928, all health visitors appointed for the first time are required to possess the certificate in Health Visiting approved by the Ministry. This actually means that all health visitors in future will be fully trained registered nurses, with six months' additional training in Health Visiting.

In Warwickshire no attempt is made to include bedside nursing in the general scheme of county public health work, as a voluntary organisation known as the County District Nursing Association is organised for that purpose.

The health visitors are responsible for following up the birth registrations in the entire county, with the exception of the boroughs of Nuneaton, Leamington and Sutton. In 1927, of the 4,912 births registered, first visits were made to 3,135, and with revisits to infants and pre-school children each health visitor averaged 653 visits in her infant and pre-school work. There are thirty-four infant welfare centres in the county. A health visitor attends each time the centre is open and acts as superintendent, thus insuring uniformity of management and co-ordination of the work of the voluntary committees, which play such an important part in all health and social work in England. Most of the infant welfare centres are provided and equipped by voluntary committees but must meet with the requirements of the Ministry of Health and be approved of by the medical officer of health, before they can be established or receive the

grant of 50 per cent. of cost of total maintenance from the Ministry.

The clinics are conducted in much the same way as the clinics in Canada. A doctor is in attendance and examines new arrivals, also all babies not showing a regular gain in weight. Sick babies are referred to the family physician for treatment. An attempt is made to examine some of the pre-school children but due to a limited staff and pressure of time only a few seem to find their way into the examining room.

#### VOLUNTARY WORKERS

Voluntary workers look after the toddlers and so leave the mothers free to listen to the advice given by the doctor about the infant. Several of the infant welfare centres serve as ante-natal and school treatment clinics. Usually a room is reserved for the pre-school children, where they are allowed to play and where, under the supervision of a member of the committee, who has, if possible, had some experience in nursery schools, they acquire some idea of the early habits so essential to healthy child life. Short health talks are given to the mothers by the doctors or health visitor. These health talks frequently deal with the important subject of nutrition, as it is well known that malnutrition usually begins in infancy and has become a habit of the body before school age. It is believed that poverty has much to do with malnutrition and may be a direct cause, but more often poverty is the indirect cause as it is so frequently accompanied by ignorance, unsatisfactory home conditions and disease. Samples of children's garments are on exhibition and material for baby clothes is sometimes sold at cost price and occasionally cod liver oil, virol and different forms of dried or canned milk are also for sale, especially in very poor localities.

#### MIDWIVES

The supervision of all the midwifery comes under the direction of the Medical Officer of Health. The

superintendent of health visitors is the County Inspector of Midwives, and it is realised that adequate ante-natal supervision is the true preventive midwifery. Only midwives who have received their certificate from the Central Midwives Board are allowed to practise. Normal cases attending the ante-natal clinics are recommended to make arrangements for their confinement with a midwife at an early date. When any abnormality occurs the midwife must call a doctor, and within twenty-four hours send in writing a notification to the Medical Officer of Health. This notification is followed up by a visit from the inspector of midwives or one of her health visitors. The midwife looks after the mother and baby for ten days after the birth and the health visitor makes her first infant welfare visit after that date. Of 6,493 births 4,887 or 75 per cent. of all births were attended by the 200 midwives practising in the county. The maternal mortality for 1927 was 3.3 per 1,000 births. The maternal mortality for the same year in the province of Ontario was 5.72 per 1,000 births. Maintenance grants in respect to midwifery services to the amount of £1,370 were made by the County Council to the County Nursing Association and one unaffiliated association. These grants were for the purpose of benefiting motherhood, insuring greater care during delivery and improving the health of the expectant mother.

#### SCHOOL MEDICAL INSPECTION

The County Medical Officer of Health, as school medical officer, is responsible for school medical inspection. Through power given by the Education Act the system in England provides for the routine medical inspection by specially appointed school doctors of all children in attendance at school three times in their school life: at entrance, at 8 years of age and at 12 years. Mentally or physically sick children of any age between five and fourteen may also be brought



before the school medical officer any time during school life.

Sir George Newman, as Chief Medical Officer for England, states in his last annual report of the health of the school child that the school medical service in England aims to:

1. Fit the child to receive the education provided for it by the state.
2. To detect any departure from the normal health and growth, and advise the remedy.
3. To seek the causes and conditions of the defects, and, as far as possible, prevent them.
4. To teach and practise personal hygiene in every school, so that a habit of hygiene may be contracted by the children.

The health visitor arranges for all medical inspections, notifies the parents and is present at all physical examinations. She is responsible for the weight charts, and does the first testing for vision and examines the children for pediculosis, scabies, ringworm, etc. She must also attend school treatment centres for minor ailments. These centres are seldom in the school but some building adjacent to the school is equipped for this purpose. In the villages the school treatment centre is open usually one or two half-days in the week.

If there is no Care Committee the school nurse does her own follow-up visiting: 3,000 children is the maximum number that one school nurse is allowed to look after.

The school medical service includes the development of a scheme for the treatment of crippling defects. Four orthopedic clinics have been provided by voluntary committees at selected places in the county and approved by the County Council and the Ministry of Health. The real success of this orthopedic work depends upon the early discovery and treatment of defects, and especially is this true of infantile paralysis which is responsible for a large proportion of all cases of crippling. Orthopedic clinics are open to all ages, but special attention is given to pre-school and school-age children.

The question of the mentally defective and epileptic children presents

much the same problem as in Canada, although more institutions for treatment seem to be available. Special classes are held in the elementary schools for the educable feeble minded, and when it is necessary to send them to a special residential school they must be sent outside the county of Warwick.

County tuberculosis work also comes under the guidance of the Medical Officer of Health. In Warwick seven dispensaries were in operation in 1928—all ages are eligible for treatment and advice. Contacts are referred for examination. There is an After Care Committee connected with each dispensary to provide financial help, give relief in the way of clothing and extra food, arrange for suitable employment and assist with care of children whose parents are in sanatoria, etc.

From these statements one can see that county health work is broad in scope if carried out with an adequate staff and equipment and proper administration.

Sir George Newman, in his last annual report on the state of the public health, says, "The improvement and perfection of the three implements of public medicine—a competent medical profession, a sanitary environment, and economic and effective public medical services is a matter of time and vigilance, of steady growth and wise amendment. In them we are building for generations to come."

#### PERCENTAGE OF MEMBERS OF PROVINCIAL ASSOCIATIONS WHO ARE SUBSCRIBERS TO:

#### The Canadian Nurse

Ontario .....	89.75%
Saskatchewan .....	66.66%
Manitoba .....	38.18%
New Brunswick .....	31.75%
Alberta .....	26.2%
Nova Scotia .....	22.33%
Prince Edward Island ....	13.50%
Quebec .....	12.17%
British Columbia .....	9%

## *Manitoba School of Social Science*

The establishment of the Manitoba School of Social Science, is greatly appreciated by those who have wished for the provision of means whereby social workers could obtain a course of study on subjects relative to Social Science.

This course, established under the authority of the Department of Health and Public Welfare and the Department of Education, of Manitoba, opened on October 1st, 1929. Lectures on the following subjects will be given: Economics, Sociology, Psychology, Psychiatry, Legislation, Public Health and Principles of Case Work.

Until such time as the development of the School requires a different organisation, the courses of study necessary for a diploma will be for two years in sequence, but candidates

for a diploma may take examinations at the end of any academic year subject to the provisions for attendance.

Students seeking instruction in separate courses with a view to specialisation in some field, or seeking a diploma at the completion of the courses for two years are requested in addition to satisfactory examinations to attend 75 per cent of the lectures given in the subjects for which recognition is sought.

Academic qualifications of students must be matriculation, or its equivalent, or an adequate period of social service. Arrangements will be made for qualified students wishing to attend lectures in one or more courses. Special arrangements may be made where and when practicable for nurses and others working in rural parts to receive instruction by correspondence.

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## *Book Reviews*

**Nursing Mental Diseases**, by Harriet Bailey, R.N., Secretary, Board of Nurse Examiners, Education Department, University of the State of New York. Second edition. Published by The Macmillan Company of Canada, Toronto, Ont. Price \$2.25.

The publication of this new edition of a very useful volume is most timely, in view of the increasing interest in the care and treatment of mental disorders.

The author, who has had a wide experience as a nurse educator in this special nursing service, presents the subject in a way that not only holds the interest but makes it readily understandable.

The Psychological Introduction sets forth simply some of the laws that control human thought and conduct.

The chapters on The History of the Care of the Mentally Ill, Some Legal Aspects of Mental Disorders, and The Prevention of Mental Disease, contain much helpful information about these little known subjects.

The remaining chapters deal with symptoms and different types of mental disorders and the specific nursing care of each.

Technical terms are avoided, but a list of terms with definitions most commonly heard and used in histories, bedside clinics, etc., is

appended, also a list of text and reference books.

To those engaged in the work this book will be useful as a reference.

Those interested in the subject will find it very helpful in whatever work they are engaged.—MARY L. JACOBS, Ontario Hospital, London, Ont.

**Elementary Materia Medica, including Drugs and Solutions**, by Walter W. Krueger, Ph.D. 278 pages, illustrated. Published by McAlinsh & Co., Limited. Toronto. Price \$1.75.

This work is practical in content and applicable for student nurses' use, inasmuch as the book all through is clearly and simply written. In introduction, it defines Drugs, purposes and sources, with the few necessary definitions, explanatory of the terms used in *Materia Medica*.

The second chapter, entitled "Historical Background of Modern *Materia Medica*," should prove of great interest to students, as it links up with teaching of History of Nursing. Prepared tables throughout the book are simple and easily memorized.

Chapters 7 and 8, arithmetic review and weights and measures, should help the student to a thorough understanding of each

principle developing the practical knowledge essential in a nurse.

The chapters on Preparation of Solutions, Antiseptics and Disinfectants, fill a long-felt want with the accurate and simple methods of procedure, application of rule, finishing the chapter with a set of problems sufficient to prove to the instructor whether the students have grasped the essential points in teaching; also the assigned questions gather definite information proving if the students understand *Materia Medica* terms.

The whole book is simple, practical, applicable, placing the subject before the students in an attractive manner, readily absorbed, and not easily forgotten.

Hitherto, *Materia Medica* books placed in students' hands cover much beyond, and unnecessary for student nurses in time allowed by approved curriculum.

This book appeals as being essentially a book prepared for students, as shown by simple methods and procedures taught throughout.—MARY F. BLISS, Supt. of Nurses, Guelph General Hospital.

**Public Health and Hygiene**, by Charles Frederick Bolduan, M.D. W. B. Saunders Company, Publishers, 1929. McAinsh & Company, Limited, Toronto, Canadian Agents. Illustrated, 304 pages. Price \$2.75.

There has long been a need for just such a brief outline of public health hygiene as Dr. Bolduan has written. Apart from a few lapses into technical terms, the material is presented in a simple, accurate, yet very readable form, which should be particularly suitable for students who do not intend to specialise in this field, but who are expected to have an intelligent grasp of the subject.

The introductory historical chapter is especially commendable in that it gives a broader view of public health work and outlines the early discoveries which made a more rapid advance in knowledge possible. In a book of this size, the selection of material is inevitably difficult, and it is gratifying to note that the diseases of middle and later life and accidents have not been neglected. Compared to some of the other chapters the section dealing with epidemiology and vital statistics is perhaps disappointing, and might be confusing to the average reader, but in attempting to compress so much information into a small volume, the author has succeeded remarkably well.—DR. F. FRASER, School of Hygiene, University of Toronto.

**The Nurse in Public Health**, by Mary Beard. Published by Harper Bros., New York and London. 211 pages. Price \$3.50.

One's first thought on reading "The Nurse in Public Health," is that the book needed to be written in order to bring the documentation on this topic up to date.

This is a book which the beginner in public health nursing should not fail to read, as it is full of information which has first been assimilated by the writer and then arranged by her in such a way as to throw salient points into high relief. A few systems of public health administration are outlined in detail, so as to give the reader a bird's-eye view of their objectives and methods. To Canadian readers the article on "Official Control in a Large City—Toronto," is of special interest.

Miss Beard has made a good point in comparing the work of public health nurses ten years or more ago and today. In the beginning she says it was the inspired efforts of individual nurses that counted; today, effectiveness depends largely on organisation and unity of purpose, with the staff conference as one means of accomplishing this.

The practical question of cost of services is not lost sight of in weighing comparative values of services to the community. This aspect of the problem is apt to be given scant consideration by writers of less extensive experience than the author. No matter how ideal a service may be, if it is too costly, in the end it defeats itself.

The author sketches public health nursing, as she saw it in France, Poland and Jugoslavia, and elaborates at considerable length an account of maternal lore in England and Denmark. This develops into an interesting brief for the midwife properly trained.

As one would expect in a treatise of this nature, a spot-light is turned on the education of the nurse, but the treatment reveals no new or challenging ideas. This same criticism might be made of the last chapter, "The Future".

It is in her philosophic observations under the heading, "The Nursing Staff," that the author scales the heights. To quote in part: "When experience has taught a nurse that in her efforts to be of assistance to another person it is her individual character alone that mars or saves a situation, she acquires a quality that can best be described by the word 'mellow'. *She has learned that only by helping people to help themselves can she serve them.* There comes to her a sense of belonging to something much bigger than herself, of having an important part in a great undertaking, and of confidence in the ultimate result of the daily routine, even though the day may have been filled with discouragement and the distress of individual tragedy.

"In their own experience the staff nurses have lived out the principle which is the root of all success in their work. They believe in the dignity and value of their daily lives, knowing that they are a part of a great constructive force which must in the end correct much that is unbearable in the relations of people to one another in our present social structure. In so far as they are able to create a similar faith in those with whom they come into intimate relations in their visits, they may be successful in bringing health to the families intrusted to them."

—JEAN E. BROWNE, Director, Junior Red Cross, Canadian Red Cross Society.

## News Notes

### ALBERTA

The annual meeting of the Alberta Association of Registered Nurses will be held in Edmonton, November 18th and 19th, 1929.

EDMONTON: Miss M. Brown, Sarnia Hospital, Ont., has been appointed to the position of school nurse on the Edmonton school staff.

Miss A. D. Engelcke, Royal Alexandra Hospital, has been temporarily appointed to the Edmonton school staff, during the illness of Miss Robena Anderson.

MEDICINE HAT GRADUATE NURSES ASSOCIATION: The monthly meeting for October was held at the home of Mrs. Oliver. Miss Florence Smith read a most interesting paper, "Notes on the Congress," which was very much appreciated by those who had not the good fortune to attend the Congress.

Mrs. F. W. Gershaw has just returned from Ottawa.

Miss Garry is at present making a Tuberculosis Survey of this city.

Miss Hagerman is now in charge of the Child Welfare Clinic.

### BRITISH COLUMBIA

The twelfth annual convention of the British Columbia Hospital Association was held in Nanaimo, Vancouver Island, on September 12th, 13th and 14th. The delegates to the meeting of the Graduate Nurses Association of British Columbia were invited as guests to the afternoon sessions held on September 13th at 2 p.m. The programme was a discussion on nursing affairs, with Miss M. F. Gray, Assistant Professor of Nursing at the University of British Columbia, as Convener in the chair.

The first paper was a very interesting one read by Miss E. Forrest, Supervisor of the Infectious Diseases Hospital, Vancouver General, on "Medical Asepsis". Miss Forrest gave a detailed description of the technique used in the infectious wards of the Vancouver General Hospital. A discussion then followed as to whether it was possible to make the technique sufficiently rigid so that all danger of cross infection would be avoided while attending patients with different communicable diseases in the same ward.

Another paper read was by Professor G. M. Weir of the University of British Columbia on "Survey Problems in Nursing Education". He discussed these problems in just three ways: the Educational, the Economic, and the Social—as he explained, he had nothing to do with the technical side of nursing problems. He pointed out that many things learned when making the survey would no doubt cancel one another, and there would have to be a very open and careful investigation of all evidence and also that an open mind would have to be maintained until all facts were in. This paper of Dr. Weir's was

of intense interest to all those present on account of the present survey which is taking place throughout Canada, and Dr. Weir issued a questionnaire to all those who can assist him in this survey.

The third paper was given by Dr. A. D. Lapp, Medical Superintendent of Tranquille Sanatorium. He pointed out very forcibly the necessity of nurses in training having at least two months' intensive work during their training period in a tuberculosis sanatorium. He suggested that the sanatorium would pay the travelling expenses of the nurses to and from the sanatorium and also that they would be given the same status as they were enjoying in their training school. He stated that there was accommodation for over 150 nurses at the Tranquille Sanatorium. This proposition of Dr. Lapp's met with a great deal of discussion from the floor, as, due to the very large number of pupil nurses training in the province at the present time, it would be difficult apparently to give each of these nurses in training a two months' experience at a tuberculosis sanatorium; also other difficulties would have to be considered in order to achieve this effort so as not to upset the training school routine or interfere with the patients' treatment at the sanatorium.

The meeting closed at 4.30 and all the guests were entertained by the directors of the Nanaimo General Hospital at a reception, cars being provided by the courtesy of the Nanaimo service club members. The delegates were shown over the hospital and very hospitably entertained to tea.

The Graduate Nurses' Association of British Columbia met on Friday, September 13th, at 8.15 p.m., in St. John's Ambulance Hall, Nanaimo, Vancouver Island. Reports were read from the I.C.N. Congress by Miss Dutton, the delegate from the Association. Dr. Harvey Agnew, of Toronto, gave an address on nursing problems in small hospitals. This address was most enlightening and showed up the many problems and difficulties which the superintendent of a small hospital has to face and be able to conquer. Dr. Agnew discussed the question as to whether it is better to have small hospitals as training schools, or staffed with graduate nurses. There were many pros and cons relating to both sides of this question—some thinking that small hospitals were better managed with graduates, while others again considered that the nurse in training was the better solution of the small hospital's problems. This was a very interesting paper and called for a great deal of discussion.

Meetings of the Nursing Education, Public Health Nursing and Private Duty Nursing committees were held on September 14th at Nanaimo General Hospital, followed by afternoon tea at the invitation of Miss Boggs of the hospital staff. The meeting



closed by the nurses making a tour of inspection over the hospital, which is a very new and up-to-date structure.

There was at these meetings a good representation of the nurses of British Columbia, and the meetings were most successfully conducted, for all the nurses went away feeling that they had learned from the different speakers to whom they had the pleasure of listening.

The Vancouver Graduate Nurses Association had their first meeting of the season on September 11th at the new Nurses' Home, Miss M. Campbell in the chair. After the business of the evening was finished, Miss Turnbull gave a most interesting report on the I.C.N. Congress. Miss Dutton also spoke briefly on some of her impressions of the Congress. After a hearty vote of thanks to both speakers, the meeting adjourned to the Reception Room, where refreshments were served.

Mrs. E. D. Calhoun, former Superintendent of the Vancouver Victorian Order of Nurses, was visiting in Vancouver during August, and while she was in the city Miss Duffield, the present Superintendent of the Victorian Order in Vancouver, gave a tea in the Hotel Georgia, at which Mrs. Calhoun was enabled to meet many of her old co-workers and friends of former days. We are glad to be able to say that Mrs. Calhoun is looking very well and is enjoying her work in the States very much.

**GENERAL HOSPITAL, VANCOUVER:** Dean Coleman of the University of British Columbia was present at the meeting of the Alumnae held on October 1st, and gave a most enjoyable talk on "Poetry and the Child".

At the business meeting which followed arrangements were made for a social evening to be held early in November.

### MANITOBA

**GENERAL HOSPITAL, WINNIPEG:** Miss Cora Taylor (1920) has returned to Toronto, where she has joined the nursing staff, Board of Public Health. Last year, Miss Taylor attended the Public Health Course for Nurses at Bedford College for Women, London, England.

Miss S. J. Pollexfen (1917), has returned to Winnipeg after spending the summer months visiting in England. Our sympathy is extended to Miss Pollexfen on the death of her father in London, England.

Misses Gugin and Miller (1929) relieved on the staff of the Social Service Department of the Hospital during the summer months.

Miss Kate Findlay (1914), of Kaleden, B.C., has returned from a most enjoyable holiday spent in Honolulu.

Miss Ray (1924) has accepted the position as supervisor of the medical wards in the Hospital.

Miss K. Oliver (1917), of New York, and Miss Crummy (1917), of California, visited in Winnipeg during September.

Miss M. Montgomery (1907), Lady Superintendent of Qu'Appelle Sanatorium, has

accepted a similar position at the recently-built sanatorium, Prince Albert, Sask.

Miss Isabel Mortimer (1916), of Mexico, is taking Miss Montgomery's place at Qu'Appelle.

Mrs. Holly (1906) is at present a patient in the Hospital.

### NEW BRUNSWICK

**CHIPMAN MEMORIAL HOSPITAL, ST. STEPHEN:** Miss Estella Murphy is a patient in the Hospital recovering from a surgical operation.

Miss Jennie Sinclair has resigned her position as Night Supervisor, and is now in Cleveland, Ohio, taking a course in Anaesthesia.

Miss Bessie Bamfill, after one year's absence in Labrador, has returned to the Hospital as Night Supervisor.

Misses E. Murphy, M. McMullen, and Grace Moffat, Superintendent of the Hospital, attended the International Council of Nurses' Congress in Montreal.

Miss Darker, Operating Room Supervisor, has a two months' leave of absence. Her position is being filled by Miss Bavis.

Misses Eileen O'Brien and Estelle Gibbon have gone to Torrington, Conn., to do institutional work.

Much sympathy is extended to Miss Irene Sherrard in the death of her little niece.

### NOVA SCOTIA

**ST. MARTHA'S HOSPITAL, ANTIGONISH:** The Commencement Exercises of the School of Nursing took place on September 24, at the Celtic Hall, Antigonish. The auditorium was tastefully decorated in the class colours of blue and white, which blended pleasingly with the arrangements of flowers.

Rev. Lewis MacLellan, pastor of St. Ninian's Cathedral, presided. His Lordship, Right Reverend Bishop Morrison, of Antigonish, conferred the diplomas and gave a soul-stirring address to the graduates. Mrs. J. H. Stewart and Mrs. J. H. Bonner, of Antigonish, presented the class pins.

The members of the class were: Marie E. Abbott, Catherine F. MacDonald, Stella K. MacDonald, Martha B. Fougere, Frances E. King, Julia H. Cameron, Bessie E. MacIntosh, Helen H. Sutherland, Opal Forrestal, Margaret E. Macleod, Margaret Fougere, Mary U. Boyle.

Rev. E. Lockhart, pastor of Saint James' United Church, gave a splendid address replete with good practical advice to the graduates, after which the class solemnly pronounced the Nightingale pledge.

Miss Stella K. MacDonald opened the function with a few well-chosen words of welcome to the large crowd who were gathered to do them honour, which was followed by a song of welcome from the student nurses. Miss Anita MacDonald read a very fine essay on Nursing Ideals. Miss Mary U. Boyle closed this enjoyable programme by a touching and well-worded valedictory, after which the audience sang the National Anthem.

The Hospital tendered a banquet to the graduates and student nurses. The students' dining hall presented a pleasing picture, as it was daintily decorated with the class colours and a profusion of flowers.

### ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in October, 1929, were 1,235. Eighteen less than in September, 1929.

#### APPOINTMENTS

Miss Ella Watts (Victoria Hospital, London, and Post Graduate of University of Western Ontario, London, Ont.), as Instructor of Nurses, Public General Hospital, Chatham, Ont.

Miss Helen Brown (General Hospital, St. Catharines, 1927), as Instructor of Nurses, General Hospital, St. Catharines.

Miss Jeannette Hastie (General Hospital, St. Catharines, 1927), as Night Supervisor at the Owen Sound Hospital.

Miss Jean MacPherson (Grant MacDonald Training School, Toronto, 1928), as Instructor of Nurses in Alma Mater.

Miss Katherine Murchison (Grant MacDonald Training School, Toronto), as Instructor of Nurses, Sherbrooke Hospital, Sherbrooke, P.Q.

Miss Meta Clubine (Toronto General Hospital, 1914), has a position in the Training School Office of the Toronto General Hospital.

Miss Robson (Toronto General Hospital), who for many years was in charge of the T. Eaton Co. Welfare Department, has left to take a position on the staff of nurses, Royal York Hotel, Toronto.

Miss Mary Ackland (Hospital for Sick Children, Toronto, 1927), as second assistant in the Training School office.

Miss Lottie Muir (Hospital for Sick Children, Toronto, 1927), on the Public Health Nursing Staff at Woodstock, Ont.

Miss Jean Morrison (Hospital for Sick Children, Toronto, 1927), as supervisor of the Boys' Surgical Ward, Hospital for Sick Children.

Miss Winnifred Hudson (Hospital for Sick Children, Toronto, 1927), in charge of the Infant Ward, Hospital for Sick Children.

Misses Guida Burton and Elizabeth Riddell (Hospital for Sick Children, 1928), as Surgical Instructor and Supervisor of Girls' Surgical Ward, Hospital for Sick Children, respectively.

Miss Cecilia Fitzpatrick (Hospital for Sick Children, 1928), as assistant in the Operating Room, Hospital for Sick Children.

Miss Helen Howe (Hospital for Sick Children, 1926), as supervisor of the Operating Rooms, Hospital for Sick Children.

#### DISTRICT 1

There was a large attendance at the fall meeting of District No. 1, held at Chatham, Ont., September 14th, 1929.

Reports of the I.C.N. Congress were presented by Misses Jacobs, Parrott and P. Campbell. Informative technical papers were given by Dr. Chalk, London, and Dr.

C. B. Oliver, Chatham. Miss Teasdale, London, presented a paper on the Education of Crippled Children in the Hospital, showing how their school work is maintained.

The visiting nurses were entertained at tea following the meeting by the St. Joseph's and Public General Hospital Alumnae.

PUBLIC GENERAL HOSPITAL, CHATHAM: Miss Tinney, president, gave her home for the September meeting of the Alumnae, at which Miss A. Coll gave an interesting report on the International Council of Nurses' Congress in Montreal.

Miss Dorothy Thomas, has resigned her position as Instructor of Nurses in the Training School, and has left to spend the winter in Arizona. On September 27, Miss Thomas was the guest of honour at a delightfully arranged party at the Nurses Residence, and was presented with very beautiful sterling silver toilet articles, the gift of the staff and student nurses.

VICTORIA HOSPITAL, LONDON: Miss Belva I. Finlay, who has spent the past two years on the Victorian Order Staff, Brantford, has resigned and is taking the Public Health course for nurses, at University of Western Ontario, she having received the hospital auxiliary scholarship.

#### DISTRICT 2

GENERAL HOSPITAL, BRANTFORD: Miss M. McCormick has resumed her duties after spending her vacation in Dunnville and Toronto.

Miss W. Chute has resumed her duties after spending an enjoyable vacation at Norway Bay, Quebec.

Miss M. Zimmerman relieved during the summer months in the operating room, and Miss E. Mann relieved during September in the surgical department.

Miss H. D. Muir is spending her vacation in Burlington and Toronto. Following her vacation she is taking a month's course at the Toronto General Hospital in surgical technique before resuming her duties as operating room supervisor.

Miss D. Arnold has returned after spending an enjoyable vacation in Toronto and Port Dover.

#### DISTRICT 4

GENERAL HOSPITAL, ST. CATHARINES: The annual Alumnae meeting and election of officers of the Mack Training School was held at the Leonard Nurses' Residence on Wednesday, September 4th, 1929.

Officers elected were: Honorary president, Miss A. Wright, superintendent of the Hospital; president, Mrs. Charles Hesburn, 54 George Street; first vice-president, Miss E. Locke, Port Weller; second vice-president, Mrs. Frank Newman, 28 Chestnut Street; secretary-treasurer, Mrs. Morris Wilson, Martindale; assistant secretary-treasurer, Miss Helen Brown, General Hospital; "The Canadian Nurse" representative, Miss D. Colvin, Port Dalhousie; "The Canadian Nurse" subscriptions and press correspondent, Miss Mary Thomas, Port Weller; social committee, convener, Misses Kennedy, A.

Handley, Joyes and Mrs. Parnell; programme committee, convener, Misses Marriott, Moyes, Brown and Mrs. Dunn; A.A. and R.N.A.O. representative, Miss Brown.

Miss Esther Hanna (1926), resigned her position as night supervisor to take a course in Public Health for Nurses at the University of Toronto.

Miss A. Johnston (1927), succeeded Miss Hanna as night supervisor.

Miss Gladys Ridge (1926), is doing general duty in Vancouver General Hospital.

#### DISTRICT 5

GRANT MACDONALD TRAINING SCHOOL, TORONTO: Mrs. Caroline Ash was awarded the Alumnae Scholarship and is attending the course for Teachers in Nursing, University of Toronto.

Miss Jean MacPherson, Alumnae Scholarship award for 1928, has been appointed Instructor of Nurses of the School. Miss MacPherson attended the course for Teachers in Nursing, University of Toronto, 1928-1929, and Miss Katherine Murchison, who attended the same course, has become Instructor of Nurses, Sherbrooke Hospital, Sherbrooke, P.Q.

At a garden party, held in the Hospital grounds, in the late summer, under the auspices of the Alumnae, the sum of three hundred and ninety-two dollars was realised.

GENERAL HOSPITAL, TORONTO. Miss Ethel Cryderman (1916), who is one of the District Supervisors in the Victorian Order of Nurses, was in Toronto during September.

Miss Alice Hunter (1928), has resumed her duties on Ward A, after a long illness.

Miss Rae Shipman (1921), has left the Red Cross Out-Post at Englehart, Ont., and has gone to New York to do special duty nursing.

We wish to acknowledge some very interesting letters lately received from some Toronto General Hospital nurses in foreign fields. Space does not permit publishing the letters in full, but some of the extracts may prove enlightening and interesting. The letters will be read in detail at an Alumnae meeting.

Mrs. Norman Found (Helen Cass, 1921), writes from Seoul, Korea. She is on a committee to organise three health centres, and states that they have a nurse in Toronto now taking the Public Health Course at the University. So even with her family of four children, Mrs. Found has time to help in the nursing field.

Miss Annie Edgar (1917), is in charge of a small mission hospital at Palampur, Punjab, India. "So far this year we have had over seventy in-patients and nearly six thousand out-patients. The doctor comes once a week for operations, and to help with other work. One in-patient is a maternity case. She is one of three wives, two of whom were pregnant and have osteo-malacia. Her name is Kup Kumari. She was in hospital two months last year suffering from pelvic inflammation. She had been in labour and the village mid-wife was called to attend.

Delivery was delayed so the mid-wife performed a craniotomy, using a nail as her perforator. No wonder Kup Kumari was ill for a long time afterwards!"

Mrs. Handley Stockley (Jean Menzies, 1922), writes from the Jenkins Robertson Memorial Hospital, English Baptist Mission, Sianfu, Shensi, China. "Our hospital is a hundred bed one, and has one ward devoted to women and four to men. As I think of the Toronto General, I feel we lack much—but we heal the sick and give the blind sight, and if a man or woman has lost their legs we provide wooden ones made by the local carpenter. And we have difficulties that those at home would never dream of. Every drug, and we are always sending down for parcels such as Aolan, 914, Tetanus anti-toxin, etc., when it arrives has to have 10% tax paid on it for the privilege of receiving it. Then, too, we are six days' journey from rail head, and the freight coming through from one province to another has at times been charged almost 100% tax. This is for the privilege of carrying on medical work here." Also, "Miss Coral Brodie is in Tsinan, we worked together in Honan for nearly a year. One summer, we had the pleasure of a visit from Miss Viola Cardwell (1921), from Korea. Then too, I met Miss Cora Kilborn in Pekin; she is now back in Szechewan."

These nurses have all said how much they enjoy the articles in "The Canadian Nurse," but what they are most interested in are the news items, so please send in news, either direct to the magazine, or to the Alumnae Executive.

#### DISTRICT 5

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Gene Clark (1918) is taking the Public Health course at the University of Toronto this year.

Misses Mariam Fryer and Una Ross (1929) have been awarded scholarships for their year and are taking the Teaching and Administration course at the University of Toronto.

Miss Doris Bailey (1929) has been awarded the scholarship for Operating Room Proficiency, and is taking a post-graduate course at the Montreal General Hospital.

Misses Audry Nelles and Muriel Bazin, student nurses, attended the International Congress at Montreal.

Miss Lorraine Morrison (1924), who has been in charge of "The Cradle" at Evanston, Ill., has resigned to take the Public Health course at the University of Toronto this year.

Miss Cecilia Fitzpatrick (1928) is assistant in Operating Room, following three months' post-graduate work in Montreal General Hospital.

Miss Helen Howe (1926), has accepted the position of supervisor of the Operating Rooms succeeding Miss Mary Shaffner (Toronto General Hospital), who has held that responsible position most efficiently for six and a half years.

Misses Guida Burton and Elizabeth Riddell (1928) successfully completed the Administra-

tion and Teaching course at the University of Toronto, and have joined the Hospital for Sick Children staff, Miss Burton as Surgical Instructor and Miss Riddell in charge of Girls' Surgical Ward.

The sincere sympathy of the Alumnae is extended to Miss Potts, our former superintendent in the recent loss of her mother; also to Dr. and Mrs. H. A. Dixon (Dorothy Crossland, 1929), in the loss of their son, John David.

#### DISTRICT 10

MCKELLAR-GENERAL HOSPITAL, FORT WILLIAM: Miss Pearl L. Morrison, R.N., F.B.C.N., for the past six years superintendent of the Hospital, has resigned to accept a similar position in the Sibley Memorial Hospital, Washington, D.C., and leaves shortly to take up her new duties. Miss Morrison was the recipient of many lovely parting gifts including those from the board, doctors, staff and pupils, District No. 10, R.N.A.O.,

and American Beauty roses from the Alumnae. Miss Morrison will be succeeded by Miss Barbara Bell, R.N., M.B.C.N., who has been her assistant since 1923.

Miss Martha Racey (1928), who this year graduated in Teaching in Schools of Nursing at McGill University has been appointed Instructor of Nurses.

#### QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: Miss D. McLaughlin (1929), has accepted a position on the staff of the Laurentian Sanatorium, at Ste. Agathe des Monts.

Miss M. Clarke (1928), has enrolled for the Public Health Course at McGill University this year.

#### SASKATCHEWAN

CITY HOSPITAL, SASKATOON: Miss Jessie Smith has resumed her duties on the staff of the Hospital.

### BIRTHS AND MARRIAGES

#### BIRTHS

ADAMS—On September 1st, 1929, to Rev. and Mrs. William Adams (Jeannette Griffiths, St. Catharines General Hospital, 1924), a daughter (Luella Jeannette).

BATSTONE—On March 15th, 1929, at Luchow, Szechewan, China, to Mr. and Mrs. Batstone (Constance Perry, Toronto General Hospital, 1923), a daughter (Beryl).

BONHAM—On October 7th, 1929, at Winnipeg, to Mr. and Mrs. Bonham (Julia Swanson, Winnipeg General Hospital, 1928), a son.

CARR—On September 25th, 1929, at Laura, Sask., to Mr. and Mrs. Cecil Carr (Mamie Onken, Saskatoon City Hospital, 1927), a son.

HIRONS—On October 1st, 1929, at Saskatoon, to Mr. and Mrs. Arthur Hiron (Dorothy Smith, Saskatoon City Hospital, 1925), a son (stillborn).

MCCRIMMON—On October 1st, 1929, at Toronto, to Mr. and Mrs. McCrimmon (Marion McClellan, Toronto General Hospital, 1922), a son.

NOXEN—On August 31st, 1929, at Toronto, to Mr. and Mrs. Noxen (Nora Parks, Toronto General Hospital, 1922), a son.

SMITH—Recently, at Lucknow, Ont., to Mr. and Mrs. Reginald Smith (Edna Fletcher, Toronto General Hospital, 1915), a son (stillborn).

STEWART—On September 11th, 1929, at Saskatoon, to Mr. and Mrs. Alex. Stewart (Viola Mears, Saskatoon City Hospital, 1926), a daughter.

WIGGINS—Recently, at Montreal, to Dr. and Mrs. R. Wiggins (Children's Memorial Hospital, 1923), a son.

#### MARRIAGES

BRADLEY—WILLIAMS—On July 29, 1929, Eva Williams (Hospital for Sick Children, Toronto, 1924) to Robert Bradley.

BUSHNELL—SHACKLETON—On June 26, 1929, Mildred Shackleton (Hospital for Sick Children, Toronto, 1921) to Paul Palmer Bushnell.

CRAIG—COVENTRY—On October 4th, 1929, at Winnipeg, Man., M. Coventry (Winnipeg General Hospital, 1926), to Mr. Craig.

DICKSON—SHEDRICK—On August 17th, 1929, at Magog, P.Q., Minnie Shedrick (Children's Memorial Hospital, 1923), to Clifford Dickson. At home, Verdun, P.Q.

HENTELEFF—AXELRODE—On September 7th, 1929, at Winnipeg, Man., Lillian Axelrode (Winnipeg General Hospital, 1928), to Harry Henteleff, of Winnipeg.

JOHNSON—PARTINGTON—On September 3rd, 1929, at Three Rivers, P.Q., Mary Partington (Jeffrey Hale's Hospital, Quebec, 1925), to Godfrey Johnsen. At home, La Tuque, P.Q.

KIER—SWANSON—On September 12th, 1929, at Banff, Alta., Frances Swanson Vancouver General Hospital, 1927), to A. Kier, of Calgary, Alta.

LARKIN—CUMMINGS—On September 30th, 1929, at Calgary, Alta., Edith Cummings (Winnipeg General Hospital, 1927), to Allen Larkin. At home, Blairmore, Alta.

MATHERS—GOULDING—On September 28th, 1929, in Switzerland, G. Goulding (Winnipeg General Hospital, 1918), to Dr. A. T. Mathers, of Winnipeg.

MITCHELL—BLACK—On September 14th, 1929, at Montreal, Hazel Black (Children's Memorial Hospital, 1928), to William Mitchell. At home, Outremont.

OSBORNE—HUMMELL—On September 18th, 1929, at Chesterville, Ont., Fiedella Hummell (Children's Memorial Hospital, 1927), to Charles John Osborne. At home, Notre Dame de Grace, P.Q.

POWELL—NELSON—On August 8th, 1929, at Winnipeg, Man., Emma Nelson (Winnipeg General Hospital, 1927), to A. C. Powell. At home, Winnipeg.



ROACH—BUSH—On September 11th, 1929, at Ottawa, Hilda F. G. Bush (Children's Memorial Hospital, 1924), to Rev. Cecil H. Roach. At home, Ottawa.

RUSSELL—GRIFFIN—Recently in Toronto, Jean Griffin (Hospital for Sick Children, Toronto, 1924) to Alex. Russell.

SHAW—CRISP—On September, 28th, 1929, Anne Crisp (Vancouver General Hospital, 1925), to Donald B. Shaw, of Toronto, Ont.

SNODGRASS — MILES — On September 27th, 1929, at Saint John, N.B., Bessie C. Miles (General Public Hospital, Saint John, N.B.), to Aubrey T. Snodgrass, of Fairville, N.B.

STERLING — PASSMORE — On August 24th, 1929, at Toronto, Jennie Passmore (Toronto General Hospital, 1921), to Dr. Lloyd Sterling.

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### REGISTRATION OF NURSES PROVINCE OF ONTARIO

#### Examination Announcement

An examination for the Registration of Nurses in the Province of Ontario will be held in November.

Application forms, information regarding subjects of examination, and general information relating thereto, may be had upon written application to Miss A. M. Munn, Reg. N., Parliament Buildings, Toronto. No candidate will be considered for examination unless the completed application form accompanied by the examination fee of \$5.00, is received by the Inspector, before November 10th, 1929.  
Signed—

A. M. MUNN, Reg. N.,  
Inspector of Training Schools

NURSES—Floor Duty Nurse wanted at the University Hospital, Ann Arbor, Michigan. Salary \$90 per month with full maintenance. Applicants must be eligible for registration in Michigan. For further information write Director of Nursing, stating qualifications and experience.

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## DECEMBER, 1929

CONTENTS		PAGE
THE PRE-SCHOOL CHILD - - - - -	<i>D. G. A. Lamont</i>	709
MEDICAL ASEPTIC TECHNIQUE - - - - -	<i>- Ella M. Forrest</i>	715
COUNTY HEALTH UNITS—UNITED STATES OF AMERICA -	<i>Laura M. Gamble</i>	718
DEPARTMENT OF NURSING EDUCATION:		
EDUCATIONAL DEVELOPMENT IN THE SCHOOL OF NURSING	<i>Sister Jovita</i>	721
ELIMINATING THE UNFIT FROM THE SCHOOL OF NURSING - - - - -	<i>Elizabeth W. Odell</i>	723
DEPARTMENT OF PRIVATE DUTY NURSING:		
CORRESPONDENCE RE CONSTIPATION: ITS CAUSE AND CORRECTION -		725
DEPARTMENT OF PUBLIC HEALTH NURSING:		
MENTAL HYGIENE AND PUBLIC HEALTH - -	<i>Dr. S. R. Laycock</i>	728
BOOK REVIEWS - - - - -		734
NEWS NOTES - - - - -		736
INDEX, 1929 - - - - -		745
OFFICIAL DIRECTORY - - - - -		749



# The Pre-School Child

By G. A. LAMONT, M.D., F.A.C.P.

If we really want to be honest with ourselves, then I think we will readily admit that the subject for this period, instead of being "The Pre-School Child" would more appropriately be called "The Neglected Child." I will not enlarge further on this, but in contrast, please think of the ever present Well Baby Clinics and the established system of school health inspection. In some districts of British Columbia an effort has been made to make up for this neglect, but generally speaking the very important phase in a child's life from 2 to 6 years receives little or no attention. It behooves you to further the interest in this age-period by organised methods, and by your personal influence in the individual families with whom you are daily coming in contact. It is not my intention to deal with numerous physical defects and their relation to the condition of these children, for after all outside of physicians, where does one find a keener appreciation of the necessity of correction of physical defects in children than in a group of public health nurses. I purpose drawing your attention to some of the outstanding features I have to deal with in my practice with this early age group of children. All of us are easily led into well-fashioned grooves and inclined to carry on our work in a stereotyped fashion and it is therefore good for us at times to inquire into our mode of procedure, into our set ideas and our stock phrases as to whether we aren't hanging our methods and ideas on a lighthouse upon which the waves of changing ideas and advancement have made inroads. Thus, from the standpoint of practical application, our work is made

less effective when the application of common sense is brought to bear upon the subject.

We have with us too much mal-nutrition. Do not misinterpret me here, I mean we have from our statistics more mal-nutrition than actually exists in any given group. The reason for this is the lack of appreciation of the difference between the underweight child and the mal-nourished child and a failure to properly realise what is meant by mal-nutrition. The bug-a-boo of underweight, is fast giving way to a saner view of Nature's laws and the fundamental rules of heredity are receiving more consideration. In the world of stock, whether it be race horses or prize puppy dogs, every consideration is given to the parental stock in breeding, yet when we come to the human family it seems that we wish to ignore these fundamental principles and expect a child of a slim parentage to measure up and be compared with that of a child whose stock is of entirely different build. We all of us in our work desire to act on a practical basis, yet I do not know of any more glaring instance of the lack of its application than in this particular problem. The attitude which one must have in regard to height and weight tables, no matter which variety is used for they are all more or less the same, is that from the practical standpoint they should be considered only as a guide. It is the difference from month to month that is of importance, bearing in mind also the marked difference in seasonal gain. If over a period of several months a child does not gain or actually loses, he should then be considered pathological. What I mean is that too often the height and weight records are being used as a basis for mal-nutrition and as I previously remarked a proper

sense of appreciation of what constitutes mal-nutrition must be obtained first. Take a little laddie whose posture is good, whose facial expression is happy with bright keen eyes, whose mucous membranes are of good colour, muscles firm, and in fact one might say of such a child, that "his skin fits him." Such a youngster, be he 15 per cent. or so underweight causes me no worry whatsoever, yet repeatedly I find parents greatly alarmed over this. The idea of underweight permeates the home through reports from older school children and from endless magazine articles and papers of the present day.

What we need to worry about is not this type of child, but the one who is suffering from real mal-nutrition. In this type of child you generally have poor posture, drooping forward of the head, and rounding of the shoulders, flattening of the chest, protrusion of the abdomen, circles under his eyes, muscles flabby and "his skin does not fit him." One may often have, and in the majority of the cases does have, the question of underweight also, but do study your child first of all without the scales and height rule and then bring these measurements into play to help complete your picture. Having said all this do not think for a minute that I am trying to belittle the effort which undoubtedly all of you are making in regard to the under-nourished child, for by such work you have accomplished a great deal of good in your districts and communities. You have made the people take a greater interest in the health of the youngsters, but from your own standpoint on this subject, try to get the broader outlook. Before leaving this, there is one more thing to which I want to draw your attention, that physical defects do not necessarily bear a relation to the state of nutrition. The term "Free to Gain," if related to physical defects is misleading, a great emphasis has been placed on the necessity of

correcting a child's physical defects to prepare him for a gain in weight. Recently, a group of children of over a thousand were carefully studied and it was definitely shown that the group which, on account of their physical defects having been corrected and were considered as free to gain, didn't fare any better than the control group who were left untouched, in fact these last ones showed up a bit better. This does in no way mitigate against the importance of correcting physical defects, because there were a number of striking instances in which a rapid and persistent gain followed the correction of a defect. It does mean, however, that some physical defects are in no way related to the state of nutrition. This is one example that I had reference to a little while back when I said that we should consider our stereotyped phrases in regard to our work.

Now, let us consider some outstanding features in the child's diet. I am not going to launch out on the wide open sea of scientific diets, rippled with practical and theoretical ideas of vitamins, etc., for I think we are all familiar enough with this subject, that we can steer our craft, be it laden with green vegetables or coffee and jam through to the safe port of proper vitamins and balanced diets. I have just used the word "outstanding features" of these children's diets, it would have been more accurate to use the word "feature," for after all to me there is only one outstanding trouble and that is these children from two to six get too much CHO. Just stop and think for yourselves of the average diet of such a child and notice the prominence of starchy food. He starts off with an excessive amount of cereal, helped along by a lot of milk, during the morning a piece of bread and jam and more milk increases the amount, and at noon-time a large serving of potato and an excessive amount of bread helps along the total. A biscuit or cake during the

afternoon makes the total bigger and better, while the evening meal with the often predominating cereal supper dish with more bread and some cake, makes a fine finish to a starchy day.

I am not going into the caloric value of these meals nor a detailed consideration of the proper ratio of the food elements, but just in general I mention that after all, these children require a liberal amount of protein for waste and growth and a reasonable amount of CHO for their activities, while the adult requires an amount of protein for waste and a liberal amount of CHO for his activities. It is rarely that I have not to markedly lessen the CHO for these little folks. Cut down the cereal in the morning and make room for an egg or bacon and if necessary, temporarily discontinue the cereal until a desire is created for these other breakfast dishes. Giving the child less bread and jam and milk during the morning benefits it, in fact such a mid-morning lunch should be eliminated and an appetite left for a wholesome meal at noon. Just here if I may wander a little from my subject, I think the indiscriminate taking of milk at recess time at schools should be carefully inquired into and selected cases only considered. As for the little folks, at noon time lessen the potato, eliminate the bread and let the cereal puddings not take too prominent a place on the menu and the same may be applied to the evening meal. Now just a word as to bread: to begin with, it is not a complete food. It contains too much CHO. A proper diet should have the protein and CHO in the proportion of 1 to 4.2, and the fat to the carbohydrate as 1 to 6. In bread, however, the protein is 1 to 8.5 carbohydrate, and the fat negligible. Besides, we do not get full value for the protein ingested, since it is only utilised to about 50 per cent. compared with nearly 100 per cent. in beef. It is plain, there-

fore, that bread should only be used as part of a mixed diet.

The much debated question of brown bread versus white as an article of diet cannot be considered as finally settled. Various attempts have been made by food reformers backed by those interested financially to get people to use flour containing portions of offal, germ, etc., that is, the various brown breads, but the people on this continent and in the United Kingdom still prefer white bread and provided the diet is sufficiently varied, the question is not of much importance.

Brown bread has some advantages, which I may mention. Its content of fibre gives it more bulk, but less protein and carbohydrate nutriment than the same weight of white bread. The fibre is useful in combating constipation, though the effect is said to wear off in time. As a matter of fact, I find many times, children with obscure intestinal conditions which respond readily to the removal of whole wheat bread from their diet. The constant irritation to the intestinal mucosa sets up a state of mild chronic inflammation. One frequently finds this in a more marked state when certain well-known widely advertised products are used with the cereals. It contains a little more vitamin B (antineuritic) than white, and more mineral water. As, however, this last is largely excreted by the intestines, the excess may be left out of account. The protein especially, and also the carbohydrate in brown bread are not so easily digested as those in white bread, because the fibre seems to interfere with the digestive juices. The wise course is probably to include some proportion of whole-meal bread in a general diet.

Extra fat and protein should always be eaten with bread, and in this respect, the custom of drinking milk and eating butter and cheese with bread is sound, though of course in young children, discretion must be used.

From an economic point of view, bread must be considered one of the cheapest and best foods, for if its value be reckoned in calories, it easily heads the list. This very cheapness encourages too much reliance to be placed upon it, especially in the case of young children to the detriment of their health and growth.

There is one disease which I must mention and it is the only one I am speaking of, namely, rickets. In medicine, when we are interested in certain conditions we are on the lookout for them and so oftener find them. This, it seems to me to be the case with rachitic conditions, for I am meeting them more and more, varying from extreme cases approaching almost marked orthopedic defects to many minor bony changes, making one feel that such an opportunity as this should not be lost in gaining your interest. You can have such an effect in the first two years of life in the prevention of this constitutional disease. Cod liver oil in the dark months of the year and a liberal use of sunshine whenever available with a proper distribution of green vegetables are your safeguards. Do not feel yourself on safe ground just because the baby is breast fed, for the danger of rickets lurks here also.

Closely allied to this is another problem. For some reason people fail to realise that young children must have good teeth to masticate their food just the same as you and I. The story of the neglect of these first teeth is indeed a very old one. A great number of intestinal disturbances and allied states of malnutrition at this age are attributable to poor teeth. Many cases of general poor health are due to oral sepsis.

It is obvious that the best defence of the tooth lies in the laying down of a healthy enamel, and the use of the tooth brush and of antiseptic dentifrices can do nothing to produce healthy teeth, though they may help to preserve them when they are defective. The calcification of the

teeth begins about the fifth month of intra-uterine life and at birth the cusp of first molars of the permanent set are already laid down. By the end of the first year, a considerable portion of the crowns of the permanent set are formed. A fact not sufficiently appreciated is that by the end of the fifth year, the greater part of the second dentition is already present in the child's jaw, in its permanent form which nothing can alter, long before any of these teeth are erupted, and therefore, before they can be mechanically affected by the food taken. This early calcification requires that healthy and generous diet should be prescribed for the mother for the preservation of the primary teeth and then later, for the continued development of sound teeth in the child. wholesome well-balanced food is as usual most essential. Lack of sunshine and of fresh air and of opportunity of exercise in the sunlight are the essential factors interfering with the proper distribution and utilisation of calcium throughout the body, in the bones and nervous system, as well as in the teeth.

Of all these conditions affecting the health of these little folks, there is one outstanding, and that is the lack of rest. This problem of the unrested or fatigued child is the commonest one we have to deal with. I do not refer to the fatigue that is due to the unfitness of the child on account of an illness or uncorrected physical defects nor to the fatigue due to a certain amount of play, but to the habitually unrested child. This generally shows itself by a feeling of fatigue, actual decrease in physical strength and endurance, lack of alertness and their emotions are easily unbalanced.

We are so accustomed to ascribe the ceaseless activity of children to what we term inexhaustible energy, that we fail to recognise the fact that many of them are, as a matter of fact, going through motions of childish play without natural, spon-



taneous enthusiasm. The normal child plays hard, rests well and awakens fresh, with others it is not so.

Moreover, human efficiency depends not only on the amount of energy available for production, but also upon its conservation. The inhibitory mechanism, which protects the human machine from useless waste of energy and unrestricted activity is not fully developed in the child as is attested by his impulsiveness and lack of deliberation before acting.

We must also consider the emotional reactions of the child. If the child were living in an atmosphere free from emotional stimulation, the problem of fatigue would be quite simple. But where is there a child today who is not exposed to emotional strain, fear, worry, anxiety, excitement and nervous tensions? He is more easily upset than an adult and incidents that are made light of by the adult often make a deep impression upon the youngster.

Why doesn't the child get sufficient rest in the first place? Well, the answer I generally receive is, "He won't go to sleep" and he won't do this and won't do that, and therein lies the trouble. There is something wrong in the home. It is the parents in the majority of cases, directly or indirectly, who are to blame and not the child for receiving insufficient rest—it's home control and management, and this condition one has to ferret out and it is almost real detective work to arrive at the source of the trouble.

Then we have the little tot, who "fights sleep" but why blame him? After a pleasant and perhaps boisterous session with mother, or especially father, it's no fun to be suddenly picked up and carried off to a dark and uninteresting bedroom and no wonder a resultant cry occurs. Too much excitement before bedtime is never allowable and if going to bed is made an interesting affair and turned into a game of sorts, thus

directing the young mind, much is accomplished. No petting should be indulged in and it will gradually be born in on his mind that screaming won't purchase a reprieve.

Then there is the child who won't take his nap. Incidentally all children should have that mid-day nap. He has decided he is wasting time by sleeping in the day time. Whether sleep will come or not, a darkened room will help and possibly a little more muscular activity might be allowed!

Wakeful children and night terrors are often caused by a heavy or late meal, often too by some gruesome tale told by an adult, or a horror of some threat which has been held over them. That is, night terrors are as a rule determined by the suppressed fears of the waking hours.

May I here remark upon the fact that children need control. They need to feel a strong will directing, restraining and confining, limiting and steadying them. Only in this way can they acquire real strength of will and character as opposed to stubbornness and strongheadedness.

The argumentative child is only too familiar, questioning everything that is asked, particularly as to why he should go to bed and at last succeeds through a prolonged conversation in deferring the bed hour. Unfortunately, parents often proudly think this is an exhibition of early reasoning power.

Being afraid of the dark is a not infrequent story. Through the carelessness of a parent or nurse it is very easy for a series of dreads to be established and everything possible should be done to avoid the suggestion to fear the dark.

As I have previously stated, the "Unrested Child" is one of the worst problems we have to deal with. Unrest really resolves itself into lack of sleep and quite irrespective of an especially planned day or properly arranged rest period, all of which play an important role, in the long run the average case comes down to

the simple solution of not in bed and asleep early enough. Invariably this reflects back on the question of bad handling on the part of the parents, frequently from the lack of home discipline and training. Here we approach very near to the heart of the subject. Stripped of all that is not essential, we see the problem of management of children reduced to the interplay between the adult mind and the mind of the receptive, suggestible child. That which is thought of and feared for the child, that he rapidly becomes. Placid, comfortable parents, who do not worry about their children, find their children sensible and easy to manage, while the apprehensive, nervous parents are forced to watch their child acquire a reputation for nervousness which, as always, is passively accept-

ed and consistently acted up to by the child.

I have tried to give you a few ideas on the outstanding problems that I am constantly meeting amongst these little folks who spend the day at home, and who have not yet stepped out into the cold world. I feel that a proper appreciation of mal-nutrition and underweight will make one's work more effective. The outstanding error in the diet of these children is the excessive CHO intake. Rickets, with its aftermath in the pre-school child demands attention. Most important however of all, is the unrested and fatigued child and if there is one thing I hope may be remembered from these rambling remarks, is the old adage, "Early to bed, early to rise, makes a man healthy, wealthy and wise."

## *Adelaide Nutting and Lavinia Dock Prize*

### *For an Historical Essay Dealing With a Nursing Subject*

The History of Nursing Society, School for Graduate Nurses, McGill University, has received the following announcement and forwarded it for publication:

In honour of these two pioneer writers of Nursing History, a prize of one hundred dollars has been offered for the best historical essay submitted by a student or graduate nurse, before January 1st, 1931. The conditions are as follows:

1. The subject must be one which is directly concerned with some important phase of nursing history.

2. The essay must show original research by the writer.

3. The essay should cover from 8,000 to 10,000 words and should be type-written.

4. There should be a cover page with full title, a table of contents, and a brief outline of the subject-matter of the essay.

5. The essay should be fully documented with foot-notes and should contain a detailed bibliography.

6. The language used should be English, French or German.

Any student or graduate nurse wishing to enter the contest should write to the chairman of the History of Nursing Committee, Miss Nina Gage, 370 Seventh Avenue, New York City, giving her name, address, professional training, and experience, and two references. Each registered contestant will then receive a number which she will place on the essay instead of her name. Her name and number should be enclosed in a sealed envelope accompanying her paper, and the whole should be insured if sent by mail.

The judges will make their decision on the basis of:

1. The worth of the material.
2. The sources consulted.
3. The form of the paper.
4. The clarity and originality of the presentation.

## Christmas Message from Mrs. Rebecca Strong

Christmas, 1929.

17 Woodburn Terrace,  
Edinburgh.

My Dear Young Friends:

I am unable to thank you individually, but the Editor of your official organ, "The Canadian Nurse," has kindly allowed me to do so collectively.

I am deeply grateful to you for the very loving and touching manner in which you received me on all occasions while with you in Canada.

May I also offer you a word of encouragement. You are now starting on the same line of life on which it has been my happiness to travel, and can strongly recommend it to you as one full of joy, if followed in a true spirit of helpfulness. It is a path on which you will meet all phases of life. Allow no foolish prejudice of race, colour, creed or school to mar your usefulness. There is but one foundation for all good nursing, viz.—the spirit of loving helpfulness.

The technique to prepare you for your work is another matter. That must be acquired according to the needs of each country.

I think we have had the Armageddon, let us with one heart and mind work right loyally for the coming of the Millenium!

The establishing of peace and good-will on earth.

I wish you all a very happy Christmas, and a bright light to guide you through the coming days.

Very sincerely yours,

Rebecca Strong

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## Medical Aseptic Technique

By ELLA M. FORREST, Supervisor, Infectious Disease Department, Vancouver General Hospital

Medical aseptic technique works on the theory and principle that disease is transmitted by contact, not airborne, and in this respect it is interesting to note how far we have travelled since the time, not so very long ago, when in the event of an infectious disease such as diphtheria breaking out in a community the road was promptly barred in order to prevent people being infected in driving past the house.

Even now we are frequently asked by patients or their friends: "How do you nurses keep from taking these diseases? I suppose you keep gargling your throats all the time." Great is their astonishment and incredulity when we assure them that our greatest safeguard is often and well-washed hands. The technique is simple, easily understood, reliable, and because of its absolute cleanliness, most satisfy-

ing to the heart of a well-trained nurse.

Then, since disease is transmitted by contact, direct or indirect, it is necessary to know what constitutes direct and indirect contacts. The former are usually evident, easily taught and understood, consisting, of course, in the actual touching of an infected patient or his fresh secretions. Not a great deal of danger exists in the direct contacts because, being obvious, they are usually promptly and properly cleaned up. It is in the indirect contact that the danger lies: this is the phase of the work that makes great demands upon our alertness and vigilance, and, of course, the greater part of our ward instruction comes in here, not only with the nurses, but with everyone who comes in contact with the patient: maids, orderlies, cleaners, and dare I whisper

it—sometimes our doctors. In teaching the pupil nurses, before defining an indirect contact, it is necessary to determine that they fully understand the significance of the word "contaminated," that anything that contains or may contain the organisms of disease is contaminated. This brings us back to an indirect contact, which is the touching of something that has been contaminated by the patient. For instance, a nurse wears a gown to prevent her uniform from coming in contact with the patient or any area contaminated by him, his table, chair, etc. When the gown is removed, it is folded once lengthwise, the two insides or clean sides together, thus when it is hung up, one contaminated side touches the wall, and the wall becomes an indirect contact.

Considerable thought is required on the part of individuals working with communicable diseases to watch the indirect contacts, and it is because of the indirect contact that so much thought is necessary in evolving a technique that will prevent the spread of a disease. This technique is just as exacting in the demands necessary to the fulfillment of its requirements as that of the operating room; in fact, both are based upon the same principle, the conditions under which the two work being reversed. In the operating room, the patient, surgeon, nurse and their equipment represent the clean area; in medical asepsis, the patient, the area surrounding the patient, and the nurse caring for the patient represent the contaminated or unclean area.

Everything outside the patient's room or areas is clean, with the exception of the sterilizers or utensils used in disinfecting contaminated articles. In going more closely into the details of technique and dealing more with facilities, it would perhaps be well to start with admission of patients.

We have our ambulance entrance, used only for admission of patients; our carriage is always in readiness with an extra sheet, in which to com-

pletely drape the patient, thus preventing all contact between the patient, and his possibly infected clothing, with our clean carriage. The sheet is left in the room with the patient, the clean carriage returned to the admitting department.

The patient is undressed, put to bed, all personal clothing enclosed in clean covers and sent to be sterilized. All patients are kept in separate rooms for eighteen days following admission: at the end of this period they may, if suffering from a common disease, be placed in larger or open wards. We have not yet had sufficient confidence in our technique to place different diseases in one open ward, although this method is successfully carried out in some hospitals for communicable diseases, with the exception perhaps of measles and chickenpox, which seem to defy at times even the separate room type of medical asepsis.

**EQUIPMENT OF ROOMS.**—Each room contains equipment for general bedside care of patient, all basins, utensils, etc., remaining in room until discharge, when everything is sterilized. In rooms not provided with lavatories, bedpans and urinals are sterilized each time after use, the covers being used only once.

**CARE OF PATIENT'S CLOTHING.**—It is listed in the clothes book the same as on other wards, but in our case requires two nurses: one contaminated in handling clothing, one clean to enter in clothes book. Outside clothing is folded as smoothly as possible, enclosed in a clean sheet; other articles placed in clothes bag and sent to sterilizing room, the covering being necessary, of course, to prevent indirect contact of corridors and elevators used in reaching sterilizing room.

**ADMISSION ROUTINE.**—T.P.R.—individual thermometers are used—kept in containers with 1:3000 biniodide solution. In separate rooms, the temperature, pulse and respiration are kept in mind by the nurse, the hands scrubbed and the data recorded on pad left outside of room;



the nurse's watch is worn on the arm above the elbow. In wards of more than one patient, the T.P.R.'s are recorded on pad in ward; after all are taken, the nurse scrubs her hands and re-copies data in clean book with clean pencil.

**TAKING NOSE AND THROAT CULTURES.**—This requires two nurses, sometimes three, if the child is restless and restraint is necessary, the one holding the child and the one taking cultures becoming contaminated, the third nurse holding clean tubes that thus remain clean on the outside to be sent to laboratory. In the case of a quiet adult patient, one nurse can take swabs and keep tubes clean.

After patient is bathed, examined and all admission routine carried out, the nurse discards her gown, scrubs her hands and arms to elbows for two minutes under running water. There are three gowns kept hanging in each room, one for the nurse, one for the doctor, one for the cleaner. They are replaced with fresh gowns each morning and changed during the day if any unusual contamination takes place, such as patient coughing or sneezing on them, and in replacing gowns on hooks after use they are folded with the inside together, thus keeping free from contamination the surface that comes in contact with clothing.

**SERVING MEALS.**—Kitchens are always clean. Trays are served from there to the various rooms: they could be delivered to the individual patient free of contamination to the nurse were it not for the salt, pepper and sugar shakers, which are kept in cupboard in patient's room; the nurse takes these from the cupboard, places them on tray, and, of course, this necessitates washing of hands. If the patient has to be fed, the nurse will put on a gown. After meals the contaminated trays are placed on the carriage and taken to a sterilizing room adjacent to the kitchen. Here a maid takes charge; wearing a gown she scrapes all dishes through an opening in a metal table into a gar-

bage can beneath, after which all dishes, including trays, are placed in steam sterilizer for twenty minutes. Then they are removed to clean kitchen and washed. The carriage, table and sterilizing room are scrubbed and made ready for the next meal. Nourishment dishes used between meals are left on a metal table in sterilizing room and sterilized with next meal's dishes.

**BED LINEN.**—It is not sterilized, but soaked in a weak chloride of lime solution in the laundry and washed separately from other linen. In connection with linen, I would like to mention what I consider one of the greatest safeguards we employ: that is the use of paper napkins instead of old linen or gauze for patients' handkerchiefs. We cut the napkins in four, making pieces about six inches square. These are kept on the bedside table, used only once and placed by the patient in a paper bag pinned to side of the bed, the paper bag being changed frequently. Thus the bedding is kept free from the contamination that must occur when old linen or gauze is used and kept under the patient's pillow or in a pocket of a gown.

**NURSES.**—Nurses on duty are not segregated from other nurses. They are required to wear different uniform and shoes, and the hair is always confined in a net. When leaving the building they scrub face, hands, and arms to the elbows before resuming clean uniforms and shoes.

**VISITORS.**—Visitors may come into the corridors and see patients through the glass which separates room from corridor; only in critical cases are relatives allowed in wards and then under close supervision.

**TERMINAL DISINFECTION.**—The patient is given a bath and shampoo of soap and water in a tub, and the room used only for discharging patients, is dressed in clean clothing, and is then ready for discharge.

Rooms, mattresses, pillows and blankets are sterilized after each discharge, as are also basins and utensils. Bed, table, chair, cupboard, walls,

floors, are washed, and, if possible, left to air for several hours.

**CONCLUSION.**—The one great drawback to medical asepsis is its time-consuming properties and the increased staff, as it requires almost double. I would say, whenever a necessity for "speeding up" occurs, our technique is almost sure to suffer. Hands are not washed as thoroughly as they should be, gowns are

sometimes dispensed with (for it takes time to put on and take off a gown), and disease germs being no respecters of ward conditions, staff shortage, etc., are ever ready to take advantage of any lapse; hence the old proverb once more proves true, "Eternal vigilance is the price of success."

(A paper read at the annual meeting, 1929, of the British Columbia Hospitals Association.)

## *County Health Units in the United States of America*

By **LAURA M. GAMBLE**, Director, Public Health Nursing Service, Cattaraugus County, N.Y.

The first county in the United States to establish a health department with a full-time health officer in charge was Yakima County, Washington, and the date was 1911. Fifteen years later, on January 1, 1926, the United States Public Health Service was able to count 307 counties or districts which had such a health service.

From 1 to 307 sounds like rapid progress until we remember that there are 2600 or 2700 counties in which the population is wholly or predominately rural. Moreover, at the rate of establishment of county health units which prevailed from 1911 to 1926, it will take over a century for the rest of the rural counties to adopt such measures for the protection of their health.

Meanwhile vital statistics are accumulating which seem to indicate that the rural districts need protection. They show us that since 1920 the rural districts have had a higher death rate than the cities—from 8% to 10% higher.

There may be many explanations for this shift in death rates. Whatever the explanations are, they suggest the need for more thought and action for the protection of the health of the rural population. There is not much difference of opinion, among those best qualified to speak, that the proper foundation for rural health service in

the United States is the County Health Unit under the direction of a qualified, full-time health officer. However, county authorities, ordinarily, have not been disposed to appropriate funds for health units unless they could be convinced that public sentiment in the county approved. Therefore, the usual first step taken to secure the establishment of health units was to start a campaign of education to show the advantages and the economy possible in public expenditure.

### CO-OPERATION NECESSARY

In most communities there has been found a large latent sentiment favoring public health work. This sentiment had to be aroused and vocalised. The co-operation and support of the physicians in the county had to be solicited. Frequently volunteer health organisations would help to support and foster the plan: local clubs and associations helped. In other instances, a health committee composed of leading citizens would be formed to stimulate public sentiment. Sometimes an epidemic served to emphasise the need for more adequate health service; again a sanitary and health survey of a county showed the need for corrective measures and brought to light existing inefficiency of a part-time health service.

Except in a few instances, permanent progress has not been made in county health work without financial and technical assistance from outside

sources. The United States Public Health Service, the International Health Board and the different Foundations interested in health work have made funds and personnel available in many states to initiate the development and to assist in the maintenance of county health units.

#### LEGISLATION

In 1921, the legislature of New York State, acting upon the recommendation of the State Commissioner of Health, registered the opinion through permissive legislation to county boards of supervisors, that the next step in providing effective protection of health in the rural parts of the State was to establish local operating units larger than the townships or villages—in other words, the county unit. Two years later, a law was passed promising financial aid to any county (not containing a city of 50,000 or more) which would take advantage of the permissive legislation of 1921, to the extent of 50% of the expenses incurred.

#### TWO UNITS FORMED

Thus far, only two of the 62 counties of the State have set up county health units. The first was Cattaraugus County, which inaugurated its county health service in 1923. However, other counties in the State have become interested and many health officers and representatives of boards of supervisors and others come to Cattaraugus County to see the work in progress there.

The cost and personnel of county health units vary with the area, population and taxable resources of the county, also with the willingness of the people to provide themselves with a health service.

Appropriations for budgets vary all the way from 25c per capita to \$2 and more per capita per annum.

Programmes and activities depend upon budgets and personnel and prevailing local health situations. Each county of necessity "cuts its pattern according to its cloth". Experience has taught us that the generalised nursing service is the most practical one for county units.

#### PUBLIC HEALTH NURSE

The public health nurse has made herself an indispensable factor in this development. From the beginning, she has been a useful and acceptable agent in starting a county health programme. She has been and still is being put into virgin fields by Red Cross Chapters, local tuberculosis associations and others, to demonstrate the initial steps, to sell the idea to county officials and to point the way to the full-time county unit.

Her activities in the rural field of public health, either as a full-time health worker on the county pay-roll or as a member of a county unit, have raised many compelling questions. It may truthfully be said that the present status of rural public health nursing is that of the pioneer stage.

A well-known public health nurse recently said, "There is no single large field in public health nursing, with the possible exception of industrial nursing, which is today more in need of development and study than that of rural nursing"; and those of us who are doing rural nursing will, I think, agree with her in this statement.

What is a well-balanced rural nursing programme? How far can urban routines, etc., be applied to rural communities? What is the rural nurse to do about the social problems she meets in her rural villages and homes? In the face of travel conditions, poor roads, etc., how can the best service be rendered at a reasonable cost? How can rural nurses be provided with proper nursing supervision? These and other questions keep coming up in rural health services.

In Cattaraugus County, where I am familiar with the work and its problems, we have been trying to answer some of these questions.

It has been possible to study and evaluate services there because of the generous grants from the Milbank Memorial Fund, which have made the employment of additional personnel and special workers possible.

Studies are being made there of rural public health nursing relation-

ships, procedures and scope of activities which should be helpful.

If we interpret public health nursing as essentially a family service, including every group, from pre-natal on through to old age, every factor in the environment which has a bearing upon health, must be reckoned within the scope of interest of the public health nurse. In our urban centres, these health needs are met in varying degrees of adequacy. No one is ready to say that rural families should have any less complete public health nursing service; but at the same time, all who understand rural conditions recognise the necessity for many adjustments of nursing services to rural problems.

In closing, I should like to stress what I feel is perhaps the most funda-

mentally important factor in the success of this field of public health nursing, and that is the preparation of the nurse herself. We give the nurse doing rural work great responsibility—and if she is not prepared to meet it her story is a sad one—she must rely upon her own resources. She often is working alone far from her supervisors. When she has been well-trained and prepared for her work, she is better able to meet the many demands of her district.

We can scarcely emphasise too strongly the need for well-trained public health nurses to undertake rural nursing, and it is a branch of nursing full of interest and satisfaction. It has an appeal typically its own which few nurses can resist when they have once experienced it.

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There are still many gaps in our hospital system. Despite excellent public and private efforts, the accommodation is still far from adequate for the incurable, the convalescent, the tuberculous, or the juvenile mentally defective patient. Moreover, the alarming increase in drug addiction and the difficulty of effecting a cure under ordinary home or hospital conditions have focussed attention upon the need of special public facilities for the treatment of these unfortunates, either by the construction of special institution or by a revision of the legal authority and the physical equipment of existing neurological institutions.—From the Foreword of A Directory of the Hospitals of Canada.

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#### NOTES FROM SUBSCRIBERS

"I find *The Canadian Nurse* a most useful journal; the point of view of so many of the articles is more nearly our own than in any of the other journals."—From a New Zealand nurse.

"I am sorry to be late with my renewal for the coming year, but hope it will arrive in time for the next number as I enjoy the magazine very much and do not wish to miss a single copy. I enjoyed the Congress in Montreal so much and am now having the pleasure of reading about it. I am sorry that every nurse does not take our magazine, and hope that this will be the best year in its history."—M. N., Ontario.



## Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

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### *Educational Development in the School of Nursing*

By SISTER JOVITA, Director of Nurses, St. Martha's Hospital, Antigonish, N.S.

The educational development which marked the growth of the scientific spirit of the nineteenth century has been carried with tremendous force into this twentieth century. Perhaps there is no branch of science that has developed more rapidly than that which covers medicine and surgery, whilst hand-in-hand with these, though a little in the rear, comes their weaker twin sister, the Nursing Profession. This argues well for the human spirit of the times and brings out into bold relief a noble trait in mankind, an inborn desire to be of service to one's fellow-men. The modern poet has expressed it pithily thus:

"This world of unbelieving hearts

In wonder may behold

Proud Science bend, the slave of Him

Who cured the sick of old."

In face of the astounding development of medical science in this modern age, we may hurl back forcefully the barbed shaft of the older poet who claimed that "Man's inhumanity to man makes countless thousands mourn." Surely, in the light of present-day experience, we can loudly assert that *man's humanity to man* in the Medical Profession has brought relief from misery and pain to *countless thousands* and saved them from an early grave.

Happily, the flame of the scientific torch has also lit the taper of service for the Nursing Profession, for here, too, we find young women prepared and willing to devote their lives for the welfare of their fellow-men, and

particularly for the relief of the suffering and disabled.

In the Maritime Provinces we are as yet pioneers in the field, and though our achievements in the past have been somewhat gratifying when we consider our many handicaps, nevertheless we have a long way to travel before we reach the goal of our desires. However, the ascent is an interesting one, and the difficulties and obstacles that beset our daily course can only add to our zest in the climbing process.

The time has come when the people of our fair provinces by the sea happily realise the need of our hospitals in as far as nursing and healing the sick goes. They no longer look upon these institutions with the old-time terror in their hearts, but rather with hope and confidence, as well as appreciation and gratitude. Notwithstanding this fact, the masses of our people do not yet begin to realise the great work we have carried along educational lines through the medium of our schools of nursing. This is a free service which we have willingly given our country. The many young women who are today nursing in the Maritimes are the finished product of our schools, and for the most part they reflect credit on their respective Alma Maters. Our schools, handicapped as they are in many respects, helped not only to keep these young girls at home in a country which is losing thousands yearly through emigration, but

also made them useful citizens. To them the public looks for service characterised by judgment, responsibility, resourcefulness and capability in meeting the problems of health in conjunction with the medical profession. The education of the nurse is a very important contribution as a national service in recruiting the great army of health. When we consider the support and monetary aid which other forms of education receive, whilst we are left to struggle hopelessly with our conflicting problems, we sometimes feel like sinking under the burden. However, with the hand of a kind and merciful God to uplift us, and strengthened by the remembrance of how He has helped us to carry on His great work in the past, we shall resolutely go forward with courage and confidence.

What has been accomplished in the development of our schools of nursing? Regardless of our efforts, we must admit what we have accomplished pales into insignificance in sight of what we hope to accomplish in the future. In the first place, we have raised the standard of our schools considerably, our schools are becoming more educational centres and less workshops than they have been in the past, and, on the whole, we have a better and more systematised organisation than we had ten years ago. However, perhaps our greatest achievement lies in the fact that we realise our needs and that we are anxious to meet them at the cost of much labour and sacrifice.

What, then, are our greatest needs today in the educational development of our schools? *First*, there looms up in large letters our need of better and more highly qualified instructors, and it should be our aim to have at least one Sister on the staff with her bachelor's degree in the science of nursing. *Second*, we should not be too conservative in our ideas, and we must strive to avoid the "psychological rut" which is so detrimental to true progress. Religious nurses are more apt to fall into this snare than

seculars, simply because it is the trend of our lives to follow closely the well trodden path of those who have gone before us. The ancient philosopher, Descartes, wisely advocated a periodical airing of our ideas to eliminate dust and moth, to expose them to the strong rays of the sunlight, discard the useless pieces and repack the valuables for future use. *Third*, we should raise the standard of our schools still higher. No applicant should be considered eligible until she has completed two years in high school at the very least. In fact, a college degree or matriculation would be more desirable. *Fourth*, we should strive to interest the public in the development of our schools and keep educators in touch with what we are doing and with our needs. We should not wait for the public to seek out our needs or read them by signs from the heavens; it is our part of the programme to make them known. *Fifth*, we should look honestly into the defects in our systems. No system and no school is perfect, and we should constantly and vigorously attack defects, eradicate them and supplement only with the very best we can find in systems that have been tried and proven. *Sixth*, we are still somewhat inclined to stress too much the practical side of the nurse's education and the intellectual side too little. The student should have a broad knowledge of her subject before she applies it to the patient. The technical knowledge should be instilled first, and the practical work ought to be introduced gradually in order to train our young women for effective service. *Seventh*, though our schools do not provide for specialisation in any line of nursing, educators claim that one of the functions of the three years' course is the testing of special interests and aptitudes which the student may show during this period. We should at least be able to give her in the third year a practical insight into the main types of nursing service. If instructors are on the alert, there will be many opportuni-

ties ordinarily offered the pupil which will help to determine where her chief qualities lie, whether in the line of executive work, public health, pediatrics, teaching, supervising or other types of nursing service. In fact, the third year work should be as truly elective as we can possibly make it.

To sum up, then, in order to secure the fullest educational development in our schools of nursing we must be

prepared to conduct schools which will meet *all* the requirements, intellectually, morally and physically, whose standards are high, and whose faculty and staff can inspire the student nurse with lofty ideals and high principles, and enable her to realise more clearly and definitely the responsibilities of her chosen profession.

(A paper read at the annual meeting, 1929, Maritimes Hospitals' Association.)

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## *Eliminating the Unfit from the School of Nursing*

By ELIZABETH W. ODELL, Director, Evanston Hospital School of Nursing,  
Evanston, Ill.

A question which grows out of the preliminary report of the committee on the grading of nursing schools and its graphic presentation of the rapidly increasing surplus of graduate nurses is: "What is our responsibility with regard to eliminating the undesirable and mediocre from our schools?"

The question might be discussed under three headings: (1) elimination of candidates before they enter, this to be done on the basis of their application; (2) elimination on admission; (3) elimination during the course.

First, let us consider the letter of application itself which we may presume is intended to convey the best possible impression. If the letter is untidy, slipshod and misspelled, the director does not feel disposed to encourage the student without at least insisting upon a personal interview. Would a mental test given at the time of the interview help in checking on the information given?

As the students get well along into the first or enter the second year, the problem becomes more complex. There are the doubtful ones, who may develop later. Sometimes they do. I believe they should have a

definite understanding of their status in the school. There are some students who have made a good beginning, especially while under the close supervision of the preliminary period but who slump later, perhaps because of an emotional instability not recognised at first or because of the overwhelming experience of living in a big city. There are the few who make serious and unnecessary mistakes and from whom we must protect future patients. Last but not least, there is the occasional student who possesses that intangible something which creates a bad influence in the school but on which it is so hard to lay a finger.

Rarely should it be necessary to dismiss a third-year student.

### PHYSICAL CONDITION IMPORTANT

Next comes the question of physical condition. Unfortunately all supposedly complete records of physical examination leave something to be desired, but when we meet with findings such as "systolic murmur," "enlarged thyroid" or "fallen arches," are we justified in subjecting the candidate to the expense necessary to enter a course from which she will probably be obliged to

drop out or to struggle through for three years only to find herself unfit for the strenuous work of a graduate nurse?

In this connection may also be considered educational qualifications. In demanding a high-school education as a prerequisite, it may be assumed that the school of nursing intends to give a course in advance of high school work, or of university grade. Should we accept as candidates those students who rank in the fourth quarter of their class and whose grades are so low that no high school principal will recommend them for college work?

Let us also consider the entrance age. Could we possibly raise the requirement for entrance to twenty or, at least, to nineteen years?

Seldom does a large class enter a school of nursing that it does not become necessary to eliminate some students during the first few weeks. After a careful physical examination by a member of the staff, there are always found physical defects, not previously reported, which make it impossible for the student to continue her work. I have in mind a case of high blood pressure, high metabolic rate, and a definite thyroid enlargement. Then, there is the occasional student who is undesirable personally and who will not fit in with the class of young women that the school wishes to hold as its representative. Finally, there is the student who fails to grasp even the most elementary part of the work and who makes her teachers wonder how she ever completed her high-school course.

#### SELECTION IS SOMETIMES DIFFICULT

So far we have attempted to separate the wheat from the chaff, but the problem is not so simple as it sounds. The director of one school, when she found that she had more than the necessary number of applicants for September, after careful scrutiny of the application forms and as many personal interviews as pos-

sible, postponed what seemed to be the least desirable material until February. The February class turned out to be the better group of the two.

The whole problem is a difficult one and admits of no immediate and sweeping method of solution. For a number of years the vital question has been to secure enough nurses to take care of the patients in the hospital, and to meet the public need later. We have not always recognised the importance of employing qualified instructors who are capable of judging the calibre of the student, nor have we stopped to consider the economic loss of carrying a weak student through only a part of the course. There has always been, and will be for some time to come in many hospitals, the financial question or, in other words, the need of getting enough persons to do the work regardless of their eligibility for a profession.

There are, however, two suggestions which might be offered as a beginning toward solving the problem.

First, when a school of nursing, probably in the face of financial necessity and in urgent need of an extra pair of hands to carry on the work, has had the courage to dismiss a student because she is considered unworthy of the nursing profession, let us not receive her with open arms into another school, thereby undoing the good that may have been accomplished at a sacrifice. It never pays.

Second, if even 1,500, out of the 2,000 or more schools of nursing, would take the advice of a prominent administrator and eliminate each year two mediocre students whom they might otherwise keep merely as a means of getting the work done, employing in their places two well qualified general duty nurses, by such action they would reduce the annual output of poorly qualified graduates by about 3,000, and at the same time take care of an equal number of unemployed.



## Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,  
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### *Correspondence re Constipation—Its Cause and Correction*

Following the publication of "Constipation, Its Cause and Correction," in the October number of "The Canadian Nurse," a letter was received from a private duty nurse. A copy of this letter (published herewith) was forwarded to Dr. Page, who has kindly sent a reply in which the several points raised by our nurse correspondent are explained. Dr. Page's reply is also published herewith.

*To the Editor,  
The Canadian Nurse.*

In reference to an article published on the Private Duty Nursing page of the October number of "The Canadian Nurse," entitled "Constipation, Its Cause and Correction," I should like to refer to a statement of Dr. Page's, and if I may be permitted, repeat a question, which Dr. Page says "troubles the minds of some patients" (and some nurses, too, Dr. Page), that is, "Is there any danger in the use of mineral oil as a causative factor in the production of cancer?" Dr. Page says, "this idea must have been obtained from some published article, but we are unsuccessful in finding anything dealing with this subject." Now I should like to refer Dr. Page to a book published, I believe last year, and entitled "Cancer: The Surgeon and the Researcher," by J. Ellis Barker, with an introduction by Sir W. Arbuthnot Lane, Bart. (pub. by John Murray), in which, quoting from page 275, is the following assertion: "We have seen so far that cancer may be caused in otherwise healthy men by chronic poison-

ing with x-rays, radium rays, arsenic, aniline, tar, pitch, paraffin, etc." He also gives some data on the prevalence of cancer among tar and paraffin workers, and finds this a fact of great significance in its bearing on the central problem, which is the steady increase of the disease in civilised countries.

A review of this book was published in a Winnipeg paper (I believe the Tribune) on September 4th, 1928.

Now, perhaps Dr. Page or someone else could explain to us why working in paraffin might produce cancer, while taking it internally might be harmless or beneficial.

One more question which is also puzzling and bears on the same subject. A cancer cure has just been claimed in the case of a resident of Frankton, New Zealand, by means of injections of kerosene given at a high temperature. The patient was pronounced incurable by authorities of an Auckland hospital two years ago. After repeated injections the patient, however, has not shown any signs of recurrence of the disease. An official of the health department who examined him found that only a cavity existed where the previous cancerous growth had been, and expressed the opinion that the cure had been effective.

Now I know there is some difference between paraffin and kerosene, but why one might produce cancer under certain conditions and the other cure it under other conditions is not just clear to an unscientific mind. An article dealing with the subject would

be of great interest, as Dr. Page tells us that, "Mineral oil is our greatest ally in combating constipation, being second only to dietetic measures," it seems a pity that any sufferers from that complaint are held back from making use of its benefits by a sense of fear that it may at some distant day be found to be the contributing cause to their having developed an internal cancer. If this fear can be proved to have no foundation worth considering, the sooner it is dispelled the better.

*Dr Page's reply:*

In reply to the query arising from my recent article on constipation which appeared in "The Canadian Nurse," October, 1929, as to possibility that mineral oil might give rise to malignancy of the bowel if taken over a prolonged period of time, I might say that such is a question that has been considerably discussed in the past, and while there has been no proof as yet that such may be the case, there is an abundance of evidence to the contrary.

Dr. Ellis Barker in his work on cancer, published by John Murray in 1924, states that while the term paraffin cancer has now seemed to have gained general acceptance in the literature, the probability that such is a misnomer seems highly likely. Although workers constantly exposed to tar, pitch, and paraffin, for a period of ten years or over, may develop a cutaneous malignancy, it would seem that such is due to the impurities contained in these products rather than to the products themselves. This is supported by the fact that while the petroleum of both Canada and Pennsylvania is richer in paraffin than that of other countries, and yet the incidence of the dread malady in these fields is no higher than elsewhere throughout the world. Furthermore, Dr. Kennaway, of the Cancer Hospital Research, in the journal of Industrial Hygiene, volume five, 1927, states that he has observed many women who have worked for

years in constant contact with refined paraffin, and has as yet seen or heard of no ill effects from such work. We all have seen countless patients of cancer age who have been taking mineral oil for long periods, and yet have like Dr. Kennaway seen no detrimental results. There are many possible impurities that might prove to be the underlying cause, and many of such have been investigated. The olefines, naphthines, anilines, arsenic, phenol, pyerrol, etc., but as yet no one has been able to prove which of these it is, if indeed it is any; but all seem to agree on one point, and that is that the causative agent, whatever it may be, is removed by the refining process demanded by government regulations before it be sold for internal medication. The process consists essentially of four stages—the removal of the carbonised matter by sulphuric acid, followed by treatment by caustic soda, then neutralisation, and with filtering through finely ground charcoal.

The second question asked is a probable explanation for a supposed cancer cure claimed in the case of a resident of Frankton, New Zealand, by the injection of superheated kerosene. I feel that those interested solely in the investigation of cancer could much more ably deal with this question than I. I could find no record of the cure cited in the New Zealand or Australian journals of the past three years, and with all the world groping for any possible cure, it seems that if such a cure had been established in any country it would have been given immediate world-wide publicity. There are few chemicals that have not been tried; as yet all have proved universally unsuccessful. Drs. Marsh and Simpson in the journal of Cancer Research, volume 11, 1927, give a series of cases where the administration of tar derivatives, both subcutaneously and intravenously, have been tried experimentally on animals with cancer, and have all given negative results.

The diagnosis of cancer is not al-

ways an easy matter, and one would have to know whether or not the diagnosis in this case had been established by microscopic section. Many supposed malignant growths and lesions have responded to the administration of potassium iodid, which were later proven to be luetic in origin. Again, the kerosene is stated to be superheated, and is it not possible that such explains the disappearance of the

growth by cauterization rather than by any chemical action? The removal of the primary growth in the advanced stage is often useless, due to the presence of multiple secondaries in the liver or elsewhere. Could it have been on these grounds that the case was deemed hopeless? Perhaps the later developments may explain the reasons for its failure to gain more widespread recognition.

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## Adult Nervous Troubles

When lecturing at the British College of Nurses on the "Past and Present Views concerning Nervous Diseases," Miss Mary Chadwick, S.R.N., F.B.C.N., in discussing the nurses' part in adult nervous troubles, said:

"It is useless to disguise the fact that the nurse has a difficult rôle to take in nursing adult neuroses, so that she may be able to help her patients without becoming involved herself in their symptoms. So that this may be accomplished successfully, she needs to know her own psychological tendencies well and be able to recognise nervous symptoms wherever she sees them, either in herself or her patients, because it is by no means rare for the unconscious mind of the nurse to respond by some echo of forgotten events of her childhood to the requirements and nervous symptoms of her patients. This will usually be the reason why nurses find the nursing of these cases so tiring and exacting for their patience, since old conflicts are recalled in some way by their patients. These are complications that need considerable study, because they are of grave significance and require thought by all those who undertake this branch of their profession.

"We may ask ourselves, *what do patients want of the nurse who attends to them when nervously ill?* First and foremost, they wish to find a kind and loving mother endlessly understanding, patient and sympathetic, a tower

of strength to balance the weakness they feel in themselves, and upon whom they may lean. Upon occasions, we may also find patients who want the stern, almost tyrannical mother, who is dictatorial, even rough, whose orders they feel forced to obey and whose treatment helps them to feel they are suffering a pleasant martyrdom. The idea of illness is often confused with that of self-punishment, through the medium of guilt, so that the patient will believe that some ancient or forgotten sin of childhood is being amply atoned for. This will sometimes even hinder recovery, because it will seem wrong to interfere with the course of expiation or even, perhaps, with the Hand of God, Who punishes with this affliction.

"It is essential for the nurse to remember that there are serious reasons why she should hesitate to practise psychotherapy herself upon the patients she nurses, as it is better carried out by one who has no personal relations with patients such as she has, and it needs long and intensive study, that even suggestion is hedged about with dangers and difficulties, but that three powerful weapons hang in her armoury nevertheless: the *Transference*, *Identification*, and her own *Unconscious Mind*, perhaps the most important of all if she understands it."

(The British Journal of Nursing, April, 1929.)

## Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,  
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

### *Mental Hygiene and Public Health*

By Dr. S. R. LAYCOCK, Department of Education, University of Saskatchewan,  
Saskatoon.

I consider it a very great honour to be allowed the privilege of addressing a group of women whose professional activities place them in the vanguard of those who earnestly strive after that great end—the happiness and welfare of mankind. Perhaps at first thought, it may seem strange that an educationist should be asked to address you, but deeper reflection will reveal the fact that our respective spheres of activity are greatly interlinked, and that, after all, we do battle in a common cause. From our side we have come to realise more and more that education is adjustment to life and that if we analyse the major interests and activities of that life to which we seek to adjust the child, health will be found as the most fundamental of all those activities and interests. So more and more schools are realising that one of their major responsibilities is health education: a health education which means more than information but which involves the building of health habits, and attitudes, and the formation of a health conscience. Turning to your side of the question, the medical and nursing professions are finding increasingly that human welfare and happiness depends not only upon having well bodies but also well minds and that psychological processes enter largely into the treatment and care of the sick.

As Dr. Blatz says in a recent book, "We do not know ourselves and the workings of our minds simply through the fact that we have a mind any more than we understand the

workings of our body and how best to regulate and control it merely because we have a body. Certain obvious things about the operation and hygiene of the body we all know and heed but when faced with the malfunctioning of the body, we readily acknowledge our ignorance and appeal for assistance to the medical man and the nurse. But how different is our attitude concerning the operations of our minds. Our mental processes—our sensations and perceptions, our memories and our ideas are our most vivid and persistent possession. Nay, indeed they are our very selves, and yet we rarely pause to analyse or to understand or to study their intricacies. And when we are faced with any difficulties concerning them our inclination is not to appeal at once for skilled assistance but to conceal those difficulties lest we be considered queer, abnormal or inferior." This attitude is perhaps not to be wondered at. It is, first of all, intensified by social pressure and convention but it is more than that. It indicates that mental processes are so bound up with the realities of life that the frank examination of them presents a difficulty. Secondly, it indicates that notwithstanding the fact that these mental processes are forever with us, they are no less intricate, puzzling and subject to major and minor disorders than our bodily processes of which we are less directly aware. Finally it suggests that the old maxim of Socrates, "Know thyself," is today taking on new meaning and leading us slowly but surely to a broader conception based upon a fuller knowledge. And

(\*Read at the annual meeting, Saskatchewan Registered Nurses Association, April, 1929.)



so today there is gradually growing up a body of principles in mental hygiene which in years to come will play as fundamental a part in public health as the principles of physical hygiene are doing today.

The idea of mental hygiene is not new. The principle was clearly indicated by that great old intellectual giant—Plato—when he urged upon physicians to consider the souls of their patients as well as their bodies. But in the period between then and now the attitude of humanity towards the problem of mental malfunctioning presents a sorry spectacle. In primitive times individuals afflicted with mental disease were often regarded as inspired by the gods or as possessed by evil spirits. In the former instance they were frequently revered as oracles and prophets, in the latter they were shunned or turned over to the incantations of the medicine man. At a later period after the Christian religion had obtained a firm foothold and the old gods were relegated to the status of demons, abnormal behaviour due to mental troubles was regarded as indicative of communion with evil spirits and much of the witchcraft persecution was levelled at individuals whom modern psychiatry would class as victims of mental disorders of one type or another. In some instances, it is true, in which the disordered mind became warped along religious lines, the victim was looked upon as a saint, and treated with reverence and respect. But these cases were few in number and could not begin to balance those whose mental illness resulted in untold suffering at the hands of their superstitious companions.

Even when superstitious fears did not actually lead to the persecution of the insane as witches, they were still regarded as a menace. During the 17th and 18th centuries they were thrown into dungeons, along with paupers and criminals, where they languished in chains, with which they were bound so that they

might not inflict injury on themselves or others. Even the asylums of the 19th century, although they made some effort to provide medical care for the mentally ill, still clung to the tradition of chaining. As the physicians in charge of these asylums learned more and more about their patients the treatment of the insane gradually grew more and more humane. Other methods replaced chains but it was a long time before the patient suffering from mental disease was left comparatively free as in the psychiatric hospitals of the present day. The necessity for the use of straight jackets and isolated cells is decreasing in those mental hospitals which are most progressive along the lines of modern psychiatry.

With the institution of less rigid treatment, however, a few of the insane recovered. This attracted the attention of the medical profession, and they began to apply the same careful attention to the study of mental diseases as they had previously to physical maladies. And just as in the field of physical disease, attention was first centered upon the more blatant disorders and upon therapeutic measures for those who were already diseased and only later was attention directed to the great field of prevention of which our present great interest in public health is a part, so attention in the field of mental diseases was first focussed on the study and care of those cases whose mental illness was sufficiently severe to place them in mental hospitals, and who were often chronic cases and only later did the idea of prevention arise. And just as through proper sanitation, through ensuring pure water and pure milk supply, through vaccination and inoculation, and through the general principles of hygiene applied to everyday life public health has made tremendous strides so the present movement in mental hygiene still in its infancy, is engaged in efforts to discover methods that will likewise do much to prevent mental disorders.

In Canada the Canadian Committee for Mental Hygiene celebrates this year the eleventh anniversary of its birth. Its purpose is two-fold. First, the prevention of nervous and mental disorders, and second, the better care and treatment of those afflicted. It attempts to achieve its results in three ways: by education, by dissemination of knowledge concerning the facts, and lastly, by research.

Some of the facts are astounding in their revelation. Last year there were 24,000 patients in our public mental hospitals and their upkeep was maintained at an annual cost of \$9,000,000. Dean Martin, of the Faculty of Medicine at McGill, is responsible for the statement that there are more hospital beds occupied by mental patients than there are patients in all the general hospitals of the land. If to this is added the fact that there are as many insane mental patients outside of mental hospitals as there are in them, the magnitude of the problem is appalling. Further, Canada has at present 60,000 of pronounced mental deficiency, not to mention tens of thousands suffering from more or less serious nervous disorders which can neither be classified as insane or mentally deficient.

Furthermore, Dean Martin in his presidential speech (*The Canadian Nurse*, February, 1929) of last year made the statement that approximately four per cent. of all school children (a greater number than graduate from our Canadian universities) are in need of mental hygiene treatment, without which they will inevitably become the victims of grave forms of mental disorder.

What, then, is to become of our national efficiency when mental defects result in greater national degradation than all the physical disorders combined?

These are some of the facts brought to light by our National Committee, and they have followed up these facts by a campaign of education

which is gradually introducing a new point of view into the attitude of the general public towards this problem.

Our first need is a changed psychological attitude towards the whole problem of mental disorder. Many of us have still clinging to us the dread of the asylum of olden days, which we thought of as a place to be shunned and feared and we are still apt to regard the sending of any of our friends there as the greatest of all disgraces. This attitude must pass. The insane are not different kinds of creatures. They differ not qualitatively but merely quantitatively. Mental disorders enter into the experience of every human being: it is only a matter of degree whether our disorder be some emotional disturbance, some kink in personality or a grave psychosis demanding custodial care. This is the modern view supported by scientists the world over. Why, then, should we not learn to face frankly that the morbid jealousies, the seclusiveness, the emotional upsets and the nervous dyspepsia are just as much mental disorders as is dementia praecox: for do they not arise from the same group of factors, some of them mild in type and others more severe?

Dean Martin says: "There is a good deal of misconception as to the significance of the term insanity. Insanity is really a legal term to be adjudged by the courts, not by the physician. It is merely the end product of mental and social failure, of the same group of disorders that induce the tantrum in the child, the anxiety neurosis in the girl, and the many emotional disturbances that affect life in the home."

Dr. Winslow, professor of public health at Yale, said in a recent address that the first difficulty to be overcome in a mental hygiene programme is the idea that there is a sharp line of demarkation between the sane and the insane. He further goes on to say that while it is necessary from certain legal standpoints

in an individual case to say that a person is sane or insane, yet just as there is no sharp line between those who are sick and those who are well in a physical sense, so there is no sharp line between the sane and the insane.

If, therefore, we are going to progress with an adequate programme of mental hygiene we must realise that mental hospitals are *hospitals*, namely, that they are merely a special kind of hospital where a special kind of illness is treated just as sanatoria are designed for a special kind of illness. Just as people suffer from illnesses connected with the heart, the lungs or the digestive system, so people suffer from illnesses of the brain and nervous system. As our brain and nervous system is the most delicate and complicated part of our being it seems reasonable that there will be diseases connected with it as well as other parts of our anatomy.

Another change in viewpoint that must come is in connection with the stigma and blame now attached to mental troubles. If blame should be attached it should be attached equally to all physical diseases. It should no more be attached to mental troubles than to pneumonia or tuberculosis. We never think of blaming a lame man, with whom we are walking, because of his limp yet when working on a committee with a man with a mental limp we blame him. Indeed, the accidental injury or the communicable disease may be result of wanton carelessness and the person with the lame leg or cold in the head may be really much more censurable than the person who is irritable, suspicious or difficult, or the person who is dull, slow or over conservative. Our ideal in dealing with the problem of mental deviation is to lay aside all thought and all feeling of praise or blame; to study the individual reaction, to describe what we see and then to prescribe for that condition in so far as it has been revealed.

One other point in current popular thinking — mental deficiency and

mental disorders or insanity are greatly confused. We must see clearly that these are two separate problems. Mental defectives suffer from an arrest of development from birth or from an early age. They have the mental maturity of ordinary children of 3 years, 4 years, 6 years, 8 years or 10 years, whatever the case may be. In other words they never have had normal adult intelligence. The insane are those whose minds have developed to various degrees of mental maturity, including normal and brilliant, and then have become organically diseased or functionally deranged. With the mental defectives science can as yet do little so far as restoring them to normalcy is concerned. They need education and training to develop them to the limits of their capacities, and with the higher grades to enable them to become self-supporting and self-respecting citizens.

The next point I want to raise is that of the relative importance of heredity and environment. This is a very large problem and while it is probably true that not only a large proportion of mental defect but also mental disease is hereditary, we must remember what that means in the latter case, is that certain individuals are born with a constitutional endowment that imposes certain limitations on what they can do and lays down lines of sensitiveness which it is worth while to respect. Yet our lessons from the war neuroses have shown that in any given community there are certain individuals whose mental equipment or mental balance is adequate and efficient to enable them to fulfill the responsibilities of their ordinary daily life but who, when subjected to a special stress, to an abnormal condition, when taken from their families and transplanted to an alien environment, with military discipline and war conditions, found that this equipment failed to work. Every person has a certain capacity and if he goes beyond that capacity he breaks. There are individuals who

live normal lives in the community so long as the weather is clear, but if the storm comes, if financial trouble arises, if an emotional crisis occurs, they break under the strain. As Dr. MacFie Campbell, of the Boston Psychopathic, says: "The fact that a person has an upset of a *certain type* may be due to the constitutional tendencies of that person, but the fact that the patient has an upset *at all* may be due to a special stress, a bereavement, an acute disappointment, an inner conflict, or a mounting tide of regret or remorse, for which their early adjustment in school and home did not prepare them." And Dr. Campbell goes on to say: "It does not do to look upon the attack as a predestined episode born to occur. Rather the fact that a poorly endowed person developed mental disorder at all may well be due to the fact that important issues in life were given a false value from the beginning, that the individual got little training in subordinating his demands to those of the group, in controlling the facile development of phantasies, in facing openly and intelligently the inevitable conflicts which exist in every individual. In all such cases where careful study is possible one can hardly fail to attribute considerable of the disaster to the influence of the home, the school, the economic and social environment. While one can admit that all men are not born equal with regard to constitutional endowment one must also remember that the later balance of the individual is going to be in large measure determined by the moulding influences to which he is exposed. These are the considerations that are in one's mind when one is studying in the individual case the origin of delinquent behaviour, the hysterical paralysis, the ill-balanced sexual life, the deep-seated depression, the restless discontent, the feeling of futility or the ideas of persecution with which the psychiatrist has to deal.

In dealing with the prevention of mental disorders let me remind you

again that it is not merely the disorders of people who happen to be mentally crippled and living for long periods in mental hospitals, one must think too of that host of milder mental disorders of which I shall speak in my second lecture and have produced eccentric, embittered, inhibited and distorted personalities, and make for such a huge proportion of human unhappiness. Here the trail leads more and more back to childhood and so we will consider for a few minutes some of the influences that mould or fashion these personalities and the adjustments the child has to make.

The new arrival on this earth is first of all faced with the simple tests of nutrition, of sleeping and of acquiring habits of cleanliness. During the first year the natural self-assertiveness of the individual meets with conflicting forces and his tendencies tend to become moulded and modified. The development of undesirable emotional traits in this period are in large measure due to the emotional weakness of the mother who may be guided purely by her personal feelings of affection or by laziness. Or else she may err through ignorance of what should be done. The child, therefore, decides its own bedtime, its own diet, and pays no attention to cleanliness and thus enters into the play period of life with a rather poor equipment with regard to manual activities, social relationships and habits. The child finds he must adapt himself more and more to the group. He finds that activities apparently natural provoke strong emotional reactions in the environment, and learns to adapt himself in some sort of way to these values. Some actions excite disapprobation and withdraw affection, some are punished, some topics cause horror and some are so mysterious that they cannot be even mentioned. The result of these years is largely determined by the emotional values that permeate the atmosphere of the child and which, as a rule, are not carefully elaborated products, but



are merely the expression of the emotional attitudes of the parents based upon their own constitutional difficulties and life experiences. In this period the child life is deeply stamped with a set of values, often a false and unreal set, derived from the personality, the reactions and the pronouncements of the parents.

In the school, both in the classroom and on the playground, the child prepares more seriously for the real tasks of life. He has a more impersonal discipline and he has to adapt himself to a wider group. He comes from a home with its special emotional values to mix with children whose values may be quite different. He comes from an atmosphere which may have fostered his sensitiveness to an atmosphere that may even be mildly hostile. He comes from a playground where he may have been king to a playground and school where he may be treated with little consideration. He may find that measured by the rest of the group there is a variation from his own estimate of himself. His marks may be poor and in games he may not be very successful; in social contacts he may not be able to make friends quickly; he may find that he is not personally liked, and that the boys keep aloof from him. The different standards of his comrades produce conflicts. They may look on honesty, truth and purity in somewhat different ways from what he does, their stories and behaviour may excite him; they may even get him to experiment with sex behaviour.

Due to inadequate preparation and the development of faulty values and attitudes in the pre-school years these conflicts that arise in the school child give rise to a host of behaviour problems and personality maladjustments that undoubtedly are fruitful sources of delinquency, psychoneuroses, and other forms of mental disorders. Has not the time come when attempts should be made to stop this stream of disorders more nearly at its source? The Provincial Department of Public Health of Saskatchewan,

realising the tremendous cost of institutional care and the tremendous wastage of human material has, with fine vision, entered upon a scheme whereby with the co-operation of the Canadian National Committee for Mental Hygiene and the University of Saskatchewan, a division of mental hygiene in the Department of Public Health has been formed. This, according to a recent announcement of the minister of public health, will consist of the part time services of a government psychiatrist, social worker and psychologist. All three will, it is hoped, within a year's time, co-operate in a demonstration of mental hygiene clinic to be established in Saskatoon which will deal with mild mental disorders in the hope that many cases may be readjusted and thus prevented from becoming patients of our mental hospitals. The psychiatrist and social worker will make a study of the possibility of placing selected patients in selected homes for care and the psychologist will make a study of the personality and behaviour maladjustments of school children in an endeavour to discover early traces of conflict and to head off more nearly at their source the mental disorders that cause so much unhappiness and suffering. Behaviour problems will be studied from the standpoint of diagnosis and treatment. If a patient comes to a doctor with a pain in his head the doctor does not say "naughty bad head," he tries to diagnose the roots of the trouble. If a child steals or is obstinate or sulky or bullying or nervous or shy or domineering, it is not adequate to say, "naughty, bad child." The case must be *diagnosed*, for the psychologist goes on the assumption that all forms of behaviour have a cause, often very complex and often far back in the history of the individual: a cause to be carefully sought out and remedied by adequate treatment.

There are many other aspects of an adequate programme of mental  
(Continued on page 735)

## Book Reviews

**Surgical Nursing**, by E. L. Eliason, M.D., Sc.D., L. Kraer Ferguson, M.D., and Elizabeth Keller Lewis, R.N. Published by J. B. Lippincott Company, London, Philadelphia, and 201 Unity Building, Montreal. Price \$3.50.

In this book the authors have very carefully explained surgical nursing and procedures, and have drawn upon their own experience, both in hospital and class room. In many cases, not only have they given the reason and method but have given sections in anatomy and physiology to better explain the procedures. Splendid illustrations are shown throughout the book.

The first few chapters deal with Bacteriology and inflammation, antiseptics and antiseptes, and anaesthetics. Methods in surgical nursing, pre-operative and post-operative care are described in a manner interesting and comprehensive.

Fractures and bandaging are not forgotten, and are dealt with in a practical way, showing splints and appliances in common use, and the preparation and appliance of the plaster bandage.

The chapter on Operating Room Technique should be of valuable assistance to any nurse.

Eye, Ear, Nose and Throat conditions have been clearly dealt with, and a brief outline of the essential anatomical and physiological facts are presented, also the drugs commonly used in treatment, and the care in each disease.

As this book covers all branches of surgical nursing in a very descriptive and practical manner, it should be of value to the student nurse in her case studies.—ANNA L. MCNEILL, Instructor, Winnipeg General Hospital.

**An Introduction to Efficient Study Habits**, by Maud Blanch Muse, R.N., A.M., Teachers' College, Columbia University. Published by McInish & Co., Limited, Toronto. 110 pages. Appendix, Bibliography, Index. Price \$1.00.

"The excuse for this monograph is that, to the author's knowledge, the subject has not hitherto been presented from exactly this angle. So brief a discussion cannot aspire to be more than an introduction to efficient learning techniques, but hope lies in the attempt made to stress the psychological laws and principles which underlie each study method advocated". The stressing has certainly been done: no less than three per cent of the text is taken up by the italicised versions of four laws and five sub-laws of learning, and their alternative names. Presumably as an exercise in learning the student is presented in one case with seven different names for the same law, to one of which even Pavlov's dog is tied. Ironically enough, the author reads herself a lesson in the avoidance of tautology by quoting James' simple formulation of the same law: "Put together the things which belong together."

If the reader can bring into play a principle of learning which is not stressed in the text, viz., that of disregarding non-essentials, she may doubtless profit by the many helpful suggestions which are given.—BROTHER R. PHILIP, Department of Philosophy, University of Alberta.

**Directory of the Hospitals of Canada: A Directory of the Hospitals of Canada with Maps**, compiled by the Department of Hospital Service, Canadian Medical Association and issued by the Department of Pensions and National Health for Canada. Forty-four pages.

As explained in the Foreword, the purpose of this booklet is to make readily available a list of the hospitals of Canada.

In Part 1, the hospitals are listed according to provinces under the following headings: Public Hospitals; Special Hospitals (including tuberculosis institutions); Pediatric Hospitals; Public Maternity Hospitals; Red Cross, etc.; Government Hospitals (including S.C.R.); and Private Hospitals.

A special classification of Hospitals is made in Part 2 as: Department of Pensions and National Health (S.C.R.); Red Cross; Pediatric; Orthopedic; Public Maternity; Tuberculosis; Mental and Neurological; and Hospitals for Incurables.

The total number of beds in each hospital is given, together with the number in each available for maternity and pediatric cases.

The report explains that while every effort has been made to verify information published, the expansion of hospital facilities has been so great in recent years that available statistics very soon become obsolete.

The Directory shows that there are 215 hospitals which conduct schools for nurses.

### BOOKS RECEIVED

**Diseases of Children for Nurses**, including Pediatric Nursing, Infant Feeding, Therapeutic Measures Employed in Childhood, Treatment for Emergencies, Prophylaxis, and Hygiene: by Robert S. McCombs, M.D., Instructor of Nurses at the Children's Hospital of Philadelphia. Sixth edition, illustrated. Published by W. B. Saunders Company; Canadian Agents, McInish & Co., Limited, Toronto. Price \$2.75.

### PAMPHLETS RECEIVED

The Canadian Council on Child Welfare has issued several recent publications:

**An Investment in Health—Hot Lunches for Schools in Rural Districts**, prepared by Myrtle Hayward, B.S., School of Household Science, MacDonald College, contains excellent advice and instructions on this subject.

**Play and Play Materials for the Pre-School Child**, prepared by Harriett Mitchell, B.A., R.N., Director, Montreal Division of Parental Education, is a splendidly illustrated booklet of 64 pages, which covers the subject in the following sections: (a) Play and Play Materials; (b) The Playroom; (c) The Home Play-ground.

Mrs. Mitchell has also prepared a pamphlet entitled "Group Study for Parents," as well as lists suggesting books for Parents and for Pre-School Children. These are published by the Montreal Division of Parental Education, Canadian National Committee for Mental Hygiene. These publications are welcomed by nurses as every nurse should not only find them interesting, but appreciate their value for parents, school teachers and all others interested in child welfare.

**Health Heroes—Florence Nightingale**, published by the Metropolitan Life Insurance Company, Canadian Head Office, Ottawa, is a brief, attractively-illustrated biography of Miss Nightingale.

**The Care and Treatment of Nervous and Mental Patients in General Hospital**, by Emil Frankel, Director of Research, and Thomas B. Kidner, Hospital Consultant, has been published by the State of New Jersey, Department of Institutions and Agencies. Illustrated.

## MIDWIVES ORGANISE

Under the leadership of Mrs. Mary Breckenridge, Director of the Frontier Nursing Service in Leslie County, Kentucky, the members of that service formed the Kentucky State Association of Midwives, and recently the Association became incorporated in Kentucky. The purpose for which this organisation was formed is "to foster, encourage, and, in the qualifications for its own membership, to maintain a high standard of midwifery with special reference to rugged, difficult, and economically poor areas; to do this in co-operation with the State Board of Health and the officers thereof, and in co-operation with the medical and nursing professions and with other like-minded citizens and organisations; and thereby raise the standard of midwives and nurse-midwives, who are or have been or may hereafter be engaged in the active practice of midwifery, to a standard not lower than the official standards required by first class European countries in 1929."

As far as is known this Association of Midwives is the first one organised, incorporated, and promoted by midwives in the United States. Mrs. Breckenridge is President of the Kentucky State Association of Midwives.

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(Continued from page 335)

hygiene on which I have not time to speak. For those patients in mental hospitals who are suffering from functional psychoses high hopes are entertained for the method of occupational therapy of which our institution at Battleford is such a splendid example. The therapeutic process of giving these patients interesting tasks which direct their energies into wholesome and helpful channels is, it seems to me, bound to greatly alter our conception of adequate treatment for the insane. The day when mental hospitals kept their patients sitting on benches around the walls of the ward with attendants to keep them quiet will pass over with a large proportion of cases to that process of re-education which is known as occupational therapy.

The care and education of the defectives is another problem which I

must pass over. The low-grade ones can only be handled adequately and justly by separate institutions specially designed for their care and training. The higher-grade ones must be cared for within our present school system by adequate provision for special classes.

In my second lecture I plan to speak on the mild mental disorders of ordinary folk, patients and others. At present I have tried to give you a general point of view. I hope, at least, that what I have said may quicken your interest and enlist your support in an adequate programme of mental hygiene. I know of no body who can render more enlightened and helpful service to the cause than the nursing profession.

(Part II. will be published in January, 1930.)

## News Notes

### CANADIAN NURSES ASSOCIATION

The Biennial Meeting of the Canadian Nurses Association will be held in the Hotel Saskatchewan, Regina, from June 24 to 28, 1930, inclusive.

The hostess organisation, the Saskatchewan Registered Nurses Association, has appointed the following members to the Committee on Arrangements.

Mrs. W. M. Van Valkenburg, General Convener and convener of the sub-committee on Entertainment. Conveners of the sub-committees are: Hotel Accommodation, Miss E. E. Graham; Registration, Sister O'Grady; Information, Miss J. MacKenzie; Educational Exhibits, Miss C. I. Stewart; Commercial Exhibits, Miss Naisbitt.

The progress report of the Programme Committee (Miss G. M. Fairley, convener), shows that that Committee is preparing an excellent programme; one especially interesting feature being an increase in the number of Round Tables in preference to numerous formal addresses and papers. Each of the three national sections, Private Duty Nursing, Public Health Nursing and Nursing Education, has already referred details for arrangement of Round Tables as well as the general programmes of Sections to the Provincial Sections.

Nomination forms have already been mailed to the federated associations, and before the end of the present month these associations will be notified by the Executive Committee of proposed changes to Constitution and By-laws.

### ALBERTA

CALGARY: The Calgary Association of Graduate Nurses held a most enjoyable bridge at the Colonel Belcher Hospital on October 18th. There was a large attendance of nurses and their friends.

### BRITISH COLUMBIA

British Columbia nurses sustained an irreparable loss in the death of Mrs. Margaret E. Johnson, R.N., which took place, October 19th, 1929, in Vancouver, B.C. after an illness of several months.

Mrs. Johnson was born in Truro, N.S., and trained at the Boston City Hospital, Boston, Mass. About seventeen years ago she came to Vancouver, taking over the Bute Street Private Hospital, which she owned till 1928, when she sold it owing to ill health. During this time she made it an outstanding success among the private hospitals of Vancouver. She acted as treasurer of the B.C. Hospitals Association for several years, was a member of the Graduate Nurses' Association of B.C., in 1913, and from 1915 till her resignation in 1927 served on the Executive Council of that Association as Secretary, Vice-President

and President. She was also President of the Vancouver Graduate Nurses' Association and took an active part in all nursing activities.

To the younger members of the nursing profession her death should be a reminder of the interest and time she gave towards obtaining the Act of Registration and other pioneer efforts of the Provincial Association of Nurses of British Columbia.

GENERAL HOSPITAL, VANCOUVER: At the November meeting of the Alumnae only a short time was given to routine business, after which the members enjoyed a social evening of bridge. A collection was taken, the proceeds of which will be used in sending Christmas remembrances to graduates of the school who are ill.

Dr. Malcolm MacEachern, Chicago, is once again a familiar figure in the corridors of this institution, and although here as a busy member of the Hospital Survey Committee, he finds time for a friendly word with all old-time members of the staff.

### MANITOBA

BRANDON: The October meeting of the Brandon Graduate Nurses Association was held by the Hospital Group at the General Hospital. Miss McNally gave a very full report of the International Congress. A delightful social hour was enjoyed.

The November meeting of the B.G.N.A., met in Dr. McDiarmid's office under the auspices of the Private Duty Section. Mrs. L. H. Fisher, graduate of the Montreal General Hospital, gave a very interesting paper on group nursing and refresher courses. This was followed by refreshments.

### NEW BRUNSWICK

MONCTON: Miss Ruby G. Hull, who for the past two years has been operating room supervisor at the Shore Road Hospital, Brooklyn, N.Y., has returned to Moncton, and is at present engaged in private duty nursing. Her many friends welcome Miss Hull back to their midst.

On September 11th, the local chapter of the New Brunswick Graduate Nurses Association entertained Miss Maizie Miller on the occasion of her leaving Moncton to take up a medical course at McGill University. A delightful lunch was served, and a travelling clock presented to Miss Miller from the members of the association, with their best wishes for future success of her career.

Four of the private duty nurses in Moncton have left recently to take institutional positions in the States. Miss Lucy Purdy has accepted a position as night supervisor at the Mount Sinai Hospital, N.Y. The Misses McCarthy and McFadden are engaged for general duty at the Polyclinic Hospital, N.Y., and Miss Dorothy Embree



at the Nassau Hospital, Mineola, N.Y. These nurses will be greatly missed from the local chapter of which they were all active members.

Miss Jessie MacDougall, who spent several weeks visiting at her home here, has returned to resume her duties as obstetrical supervisor at the Homeopathic Hospital, Rhode Island.

**SR. STEPHENS:** The local chapter of the Registered Nurses Association of New Brunswick met on November 8th, at the home of Miss Mabel McMullen. A delicious basket supper was served. Covers were laid for 19. The table was daintily arranged and decorated with Hallowe'en favours at each plate. After supper the annual reports were read and the usual business was transacted. The following officers were elected for the coming year: president, Miss M. McMullen; vice-president, Miss Jessie Murray; secretary-treasurer, Miss Myrtle Dunbar; entertainment committee, Miss Bertha Gregory, convener; Miss Nellie Lyons, Miss Nellie Spinney.

Miss Ella McBain and Miss Ruth Hagerman have gone to Boston, Mass., to do private work during the winter.

### NOVA SCOTIA

**HALIFAX INFIRMARY:** Sister Catherine Gerard and Sister Rose Angela of the staff, have returned from St. Mary's Hospital, Rochester, Minn. (Mayo's), where they have completed a six months post graduate course in operating room technique.

### ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in November, 1929, were 1,261, twenty-six more than in October, 1929.

#### APPOINTMENTS

Miss H. D. Muir (Brantford General Hospital), as Operating Room Supervisor in the Hospital.

Miss Frances M. McDonald (Grace Hospital, Toronto, 1919), to the staff of the Radiology Department of the Hospital.

Miss Elsie C. Ogilvie (Grace Hospital, Toronto, 1919), as Assistant Superintendent of Nurses, Neurological Hospital, Medical Centre, New York City.

Miss Beatrice Mae Tunbridge (Grace Hospital, Toronto, 1929), as Assistant Supervisor in the Obstetrical Department of the Hospital.

Misses M. E. Lavis and Mabel Casselman (Ottawa Civic Hospital, 1928), to the staff of the Hospital at Iroquois Falls, Ontario.

Miss M. Simons (Ottawa Civic Hospital, 1929), to the staff of the Indian Reserve Hospital, Brantford, Ont.

The Board of Directors of the Registered Nurses Association of Ontario held a meeting at the Academy of Medicine, Toronto, on Thursday, October 24th, 1929. All but two of the districts were represented, and splendid reports were presented from each district.

The total membership for 1928 was 1387; on October 1st there was a membership of

1,754, showing an increase of 367 members over last year.

There were 694 identification certificates issued to nurses in Ontario who attended the International Council of Nurses' Congress in Montreal in July, 1929.

During the week following the International Congress a number of nurses from foreign countries visited Toronto and surrounding points. The hospitality committee of the Registered Nurses Association of Ontario had headquarters at the Royal York Hotel, Toronto, where a member was on duty all the time. A number of the visitors called, and for many arrangements were made for entertainment, for visits to the various hospitals and institutions, and where necessary, arrangements were made for any who wished to visit other cities in the province.

The next meeting of the Board of Directors will be held in Toronto on February 6th, 1930, when final arrangements will be made for the Annual Meeting, which, it is expected, will be held in Toronto on April 24th, 25th and 26th, 1930.

### DISTRICT 1

The Florence Nightingale Nurses Association of Windsor and adjacent municipalities was formed by graduate nurses in March, 1927: membership is limited to those nurses who are not eligible for membership in one of the local nurses' alumnae.

The objects of the organisation are:

(1) To unite the nurses resident in Windsor and adjacent municipalities who are graduates of schools of nursing outside of Border Cities.

(2) To establish and maintain ethical standards among nurses.

(3) To promote the educational and social standing of the nursing profession.

(4) To assist in feasible charitable causes.

(5) To co-operate with District No. 1, of the R.N.A.O., with the Ontario Registered Nurses Association, and the Canadian Nurses Association.

From a small group of seven graduate nurses in March, 1927, this organisation has grown to a membership today of 128, and applications are still being received. All active members are registered nurses of Ontario, but the Association accepts associate members (without Ontario registration), the latter cannot hold office. The organisation is chiefly a social one. There are many married members who enjoy keeping up their professional interest through the Association.

This organisation is affiliated with the Local Social Service Council and renders support to the Victorian Order of Nurses established here in September, 1927. With the opening of the New Metropolitan Hospital in the Border Cities in March, 1928, the nurses undertook the financing of a nurse's room in the Hospital. Christmas contributions are made to the Hospital, Essex County Sanatorium and to the local Victorian Order of Nurses.

The officers are: president, Mrs. R. E. Parker, Jr., Parker Apts., Windsor; secretary, Mrs. Grace Wetmore, Devonshire Apts., Walkerville; treasurer, Mrs. D. Patterson, 1282 Dufferin Street, Windsor.

Executive meetings are held the last Monday of every month.

Regular meetings are held the first Tuesday of every month.

An invitation is extended to any nurse visiting the Border Cities at any time to join this Association. The members try to entertain every professional woman who comes to the Border Cities.

#### DISTRICT 2

The annual meeting of District No. 2, R.N.A.O., was held at the Kitchener and Waterloo Hospital on October 11th, 1929, Miss E. M. McKee presiding, in the absence of Miss M. Buck, Simcoe.

Miss Winterhalt, president of the local Graduate Nurses Association welcomed the visiting nurses.

The meeting which proved of great interest was attended by over 100 members.

An interesting report was given of the Congress, International Council of Nurses held in Montreal, by Miss MacCormack, Brantford. Miss Elsie Masters, Kitchener, spoke to the nurses on the need of continued interest in publications, both "The Canadian Nurse", and "The International Nursing Review."

Officers were elected as follows: President, Miss N. Buck, Simcoe, re-elected; vice-president, Miss E. Webster, Owen Sound; secretary-treasurer, Miss H. Booth, Simcoe; councillors, Misses Gladys Jefferson, Woodstock, Oxford County; A. Bingeman, Kitchener, Waterloo County; L. Kaempf, Guelph, Wellington County; M. Derby, Stratford, Perth County; I. Davidson, Paris, Brant County; M. Legget, Simcoe, Norfolk County; representatives to sections; public health, Mrs. J. L. Mitchell, Brantford; nursing education, Miss S. M. Jamieson, Galt; private duty, Miss J. Davidson, Paris; finance convener, Miss L. Ferguson, Guelph; membership convener, Miss E. Murphy, Guelph; publication convener, Miss MacCormack, Brantford.

After the election of officers, the meeting formed into the Public Health, Private Duty and Nursing Education Sections. The following members opened discussion: Private Duty, Miss Jean Davidson, Paris; Public Health, Mrs. Mitchell, Brantford; Nursing Education, Miss Jamieson, Galt.

Group nursing, the chief topic presented by the largest attended section, Private Duty, was discussed with great interest, although nothing definite was decided upon, and the subject will consequently receive further discussion at the next meeting to be held in Guelph, February, 1930.

After the adjournment of the meeting, refreshments were served at very attractive tables decorated with Halloween favours. Some of the nurses then visited St. Mary's Hospital, while others, due to the courtesy of the Kitchener Canadian Women's Club,

attended an illustrated lecture by Dr. Krupp, of Woodstock, on his trip around the world.

GENERAL HOSPITAL, BRANTFORD: Miss H. D. Muir has been appointed as Operating Room Supervisor following a course in Operating Room Technique at Toronto General Hospital.

Miss M. MacCormack gave a very interesting talk at the Alumnae meeting on the International Congress of Nurses which was held in Montreal, and which she illustrated with several lantern slides.

The staff entertained at high tea for Dr. Chung, of China, who is visiting in Canada.

Miss Jean Davidson has returned to her duties after spending her vacation in Toronto, where she took a course in physiotherapy at the Toronto General Hospital.

Miss Ada Blackwell, Listowel, was recently married in Brantford.

Miss Marjorie Clark, Toronto, was recently married in Toronto.

GENERAL HOSPITAL, WOODSTOCK: A successful tea was held by the Alumnae October 1st, tables in the reception room being made very attractive for the occasion. It was well patronized and brought gratifying results.

The Alumnae entertained the 1929 graduating class, November 1st, to a theatre party, followed by a banquet held at The Masonic Temple Tea Rooms, forty being present for the occasion. An enjoyable evening was spent.

#### NOTICE

The Brantford General Hospital Archives Committee urgently request a record of all former nurses trained at this school since its inception, 1888-1914. Will nurses kindly assist to further this aim by sending in their names, addresses and year of graduation, also any information re other graduates of those dates to: Miss M. MacCormack, Reg.N., Secretary, Alumnae Association, General Hospital, Brantford, Ont.

#### DISTRICT 4

GENERAL HOSPITAL, GUELPH: A prominent citizen of Guelph has very kindly donated the sum of \$5.00 towards new equipment in the Nurses Class Room.

Miss Grace Kinder, of Strathroy, and a Graduate of Hamilton General Hospital has accepted a position as Instructor at the Hospital.

A very interesting, as well as instructive evening was spent by the graduate and pupil nurses on October 24th. Miss MacDonald introduced the speaker Mrs. Haygarth, of the Social Service Department, Toronto. A number of slides were shown and a short talk given, after which a hearty vote of thanks was moved by Miss Kinder, seconded by Miss Kaempf.

Mrs. Haygarth was the guest of the Alumnae while in Guelph, when she occupied the Nurses Room in the new Y.W.C.A. This room was furnished by the Alumnae.

GENERAL HOSPITAL, HAMILTON: Miss Aileen Strachan (1928), did relief duty

on the Victorian Order of Nurses staff for the month of October.

Miss Violet King (1926) is in St. Catharines with the Victorian Order of Nurses.

Misses Catharine Chapple and Jessie McDonald (1926), have returned to New York after a holiday. Miss Vilma Hutchison returned with them.

Misses Alice Lockie and Georgina Drew (1927), have left to take positions in New York.

Miss Helen Gowling (1929), has taken Miss Lockie's place on the operating room staff.

Miss Marion Harvey is very much improved.

Miss Gladys Ayres (1922), of South Carolina is recovering from a serious illness.

Two bridge parties have been held in aid of the Mutual Benefit Association and were very much enjoyed by those who attended.

On October 26th, a very successful rummage sale was held and \$115.75 realised.

A very successful bazaar was held by the Alumnae on Wednesday, November 6th. About \$830.00 was realised which is to be given to the Mutual Benefit Association.

#### DISTRICT 5

The regular meeting of District No. 5, R.N.A.O., was held in Orillia, at the Soldier's Memorial Hospital Residence on Saturday, September 21st. The afternoon session was devoted to business and after supper, served by the nurses of the hospital, a report of the I.C.N. Congress was given by seven nurses who had attended the meetings.

GRACE HOSPITAL, TORONTO: Miss Ida J. H. Lindsay (1916), has recently returned from a trip around the world.

GENERAL HOSPITAL, TORONTO: A most delightful dinner was arranged for and held on Friday, July 12th, 1929, at the Mount Royal Hotel, Montreal, for the graduates of the Toronto General Hospital attending the Congress, International Council of Nurses.

It proved a joyous reunion for all, especially for some of the older graduates who had not met for many years.

Miss Gunn, in her inimitable way, spoke a few cheery words, and brought the dinner to a most successful conclusion.

Those present were: Jean I. Gunn, St. Luke's Hospital graduate, and Superintendent of the Training School for Nurses, Toronto General Hospital; A. J. Hartley (1902), Matron-in-chief of the Pensions and National Health, Toronto; Janet H. Neilson (1897), Supervisor, Yorkville District, Department of Public Health, Toronto; Annie I. Browne, (1895), Private Duty, Toronto; Clara A. Brown (1903), Private Duty, Toronto; Bertha Harmer (1913), McGill University, Montreal; C. Isabel Stewart (1910), Supervisor Red Cross Nursing, Saskatchewan; Mrs. Sarah M. Driver (1913), Industrial Nurse, Harris Abattoir Company, Toronto; Ethel M. Cryderman (1916), Supervisor, Victorian Order of Nurses, Ottawa; Louise M. Dickson (1916), Superintendent, Shriners'

Hospital, Montreal; Mrs. E. M. Feeny (1907), Public Health Nurse, Saskatchewan; Edna M. Squires (1916), Ontario Provincial Public Health Nurse; Mrs. Olive Elwood Smillie (1916), School Nurse, London, Ont.; Alice Thompson (1921), Department of Public Health, Toronto; Margaret Stovel (1919), Department of Public Health, Toronto; Laura L. Rowan (1920), Private Duty, Toronto; Mrs. Helen Cameron Parks (1918), Toronto; Mrs. Margaret MacLennan Smythe (1918), Toronto; Emma E. Augustine (1908), Emergency Work; Helen Longworthy (1922), Red Cross, Saskatchewan; Lorena M. Chute (1921), Staff, Toronto General Hospital; Arlie Harrison (1921), Private Duty, Toronto; H. Caroline Hugill (1921), Private Duty, Toronto; Isabel Kelley (1928), Private Duty, Toronto; Mrs. Muriel A. Martin Hughes (1920), Montreal; Elsie Hickey (1913), Department of Public Health, Toronto; Winifred McCrum (1928), Staff, Toronto General Hospital; Elizabeth Stanfield (1912), Private Duty, Toronto; Merle B. Bruce (1926), Staff, Toronto General Hospital; Annetta L. Landon (1926), Staff, Toronto General Hospital; Margaret Kellough (1926), Private Duty, Toronto; Hazel Quinn (1927), Private Duty, Toronto; Helen S. Locke, St. Luke's graduate, Assistant Superintendent, Toronto General Hospital; Athol L. Beatty (1920), Industrial Nurse, Canadian General Electric, Toronto; Gordon M. Lovell (1920), Department of Public Health, Toronto; Elsie C. Bain (1920), Toronto; E. Elizabeth Mellish (1925), Private Duty, Toronto; Edna L. Moore (1913), Canadian Tuberculosis Association, Ottawa; M. Olive Turner (1917), Private Duty, Toronto; Frances G. Charlton (1925), Staff, Toronto General Hospital; Mary E. Macfarland (1926), Staff, Toronto General Hospital; Agnes C. Neill (1926), Staff, Toronto General Hospital; Nellie Doig (1927), Private Duty, Toronto; Irene B. McElvey (1927), Private Duty, Toronto; Mrs. M. A. Moore (1902), Private Duty, Toronto; Mrs. Ethel Jeffrey Hutchison (1897), Montreal; Elvira Manning (1920), Department of Public Health, Toronto; Marion E. Stewart (1918), Department of Public Health, Toronto; L. Adele Cameron (1926), Staff, Toronto General Hospital; Mrs. Maude Kennedy Hogan (1919), Montreal; Gretta Ross (1919), Department of Public Health, Toronto; Anna M. Oram (1913), Public Health Nurse, Welland, Ont.; Elizabeth Jones (1917), Public Health Nurse, Weston, Ont.; Elizabeth H. Purdy (1905), Staff, Toronto General Hospital; Anne Wright (1919), Superintendent, General Hospital, St. Catharines, Ont.; S. Agnes Campbell (1912); Edna E. Fraser (1911), Department of Public Health, Toronto; Mrs. Bertha Gibbons Bartholomew (1909), Toronto; Madge McCort (1911), Maritime Tuberculosis Educational Association; Mrs. Helen Duff Forgan (1918), Toronto; Margaret E. Orr (1914), Assistant Superintendent, Shriners' Hospital, Montreal; Ethel Campbell (1913), Private Duty, Toronto; V.



Rae Shipman (1921), Red Cross Hospital, Englehart, Ont.; Jean L. Church (1925), Private Duty, Ottawa; Jessie Algie (1921), Private Duty, Toronto; Dorothy M. Percy (1924), Victorian Order of Nurses, Ottawa; Ethel S. Fenwick (1918), University Hospital, Edmonton, Alta; Flora C. Liggett (1909), Superintendent, Montreal Ladies Benevolent Society.

#### DISTRICT 6

GENERAL HOSPITAL, BELLEVILLE: Miss Dolly M. Church received the scholarship awarded by the Shriners' Hospital, Montreal. The scholarship includes an eight months course at McGill University. Miss Church spent two months as an affiliate student at the Shriners' Hospital about four years ago. Her many friends congratulate her on her award.

On August 15th, 1929, the many friends of Miss Annie Burley gathered at the home of Mrs. Arthur Newman, and presented Miss Burley with a miscellaneous shower. She received many useful and beautiful gifts. A very pleasant evening was enjoyed by all.

#### DISTRICT 7

HOTEL DIEU HOSPITAL, KINGSTON: The graduating exercises of the St. Joseph Nursing School were held on September 24th, in St. Joseph's Hall in the presence of a large number of friends.

The hall was very attractively decorated with the school colours, blue and white.

There are eight nurses in the graduating class: Rev. Sister St. Margaret Mary (Mary Josephine O'Keefe), Marjorie Kathleen Laroque, Reine Marie Bergeron, Lucy Marie Driscoll, Irene Margaret Garvin, Mary Helena McDonald, Mary Elizabeth Speagle, and Evelyn Marie McGown.

The Very Rev. Monsignor J. F. Nicholson, Vicar General, was Chairman for the evening.

The presentation of diplomas to the graduates was made by Rev. Father J. G. Claffey and the Rev. Mother Superior presented the hospital pins.

Rev. Father G. Koster, C.S.S.R., of Brockville, addressed the graduates in a most eloquent and inspiring manner.

Following the graduating exercises a reception was held in the Nurses Home, where the graduates received the congratulations of their friends.

The Hotel Dieu Nurses Alumnae were hostesses at a well-arranged dinner at the La Salle Hotel in honour of the graduating class, and after dinner at a dance where the student nurses of both Hotel Dieu and the General Hospital were their guests.

The student nurses entertained the Graduating Class at a very delightful dance at the La Salle Hotel, the evening after graduation.

Dr. and Mrs. J. A. Hannan (Ruth Lyons), have arrived in Edinburgh, Scotland, where they plan to spend the next two years.

Miss Amy Ada (1926), has returned to Buffalo, N.Y., after spending some time with her parents in Kingston. Miss Ada has quite recovered from a serious illness.

#### DISTRICT 8

OTTAWA: Miss K. Pridmore (Lady Stanley Institute), has accepted a position in the office of Dr. S. Evans.

Miss Norma Lewis (St. Luke's Hospital), has accepted a position as resident nurse at Ashbury College.

CIVIC HOSPITAL, OTTAWA: Miss Elsie G. McIntyre (1927), of New Haven, Conn., has been visiting in town recently.

Miss Sybil Everitt (1927), with the Victorian Order of Nurses at Moncton, N.B., has also been holidaying in Ottawa.

Miss B. J. Rumsey has resigned as supervisor and is now residing in Newmarket, Ontario.

Miss B. V. Hughes has returned to duty in the Soldiers' Ward after a long absence through illness.

Misses M. Dale and M. R. Downey (1929), are relieving in the Hospital at present.

Miss Edna M. Brown (1928), is at present taking the Public Health Course in Toronto.

#### QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss Hazel MacDonald (1927), is taking a post graduate course at the Phipp's Clinic, Baltimore.

Miss Hilda Foster (1926), is engaged in post graduate work at the Rockefeller Institute, New York.

The following have accepted positions in the Royal Victoria Hospital: Miss Catherine Dart (1929), in the Neuro-Surgical Research Department; Miss Rae Fellowes (1928), in charge of a floor in the Maternity Pavilion; Miss Beatrice Hewitt (1919), in charge of a floor in the Maternity Hospital.

Miss Marion Bradbury (1924), is seriously ill at her home in Heart's Content, Nfld.

Miss M. F. Hersey, superintendent of nurses, is spending several months in England, the guest of Miss Young, Standed.

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: A very delightful bridge was given by Miss A. S. Kinder, Honorary President of the Alumnae, on October 18th, 1929, the proceeds to go to the Flora Madeline Shaw Memorial Fund.

At the last monthly meeting, Dr. L. J. Rhea addressed the Alumnae on "Anterior Poliomyelitis". The lecture was both interesting and instructive. A delightful social hour was spent at the close of the meeting.

SHERBROOKE: A joint meeting of the Eastern Townships Graduate Nurses' Association and the Sherbrooke Hospital Alumnae was held at the home of Mrs. Guy Bryant on November 7th in order to discuss an increase in fees for maternity cases.

The E.T.G.N.A. has accepted a room in the Mackinnon Memorial Building to hold their meetings, and to give teas, etc. The graduate nurses have purchased a magnificent grandfather clock to be placed in the room as a memorial to their beloved Mrs. Mackinnon.

Misses Morrisette, Messias and Sutton, have returned from a very enjoyable trip



to Jamaica (Miss Messias' home), and are again on duty.

Several of the recent graduates have received their R.N. and are now on the register, doing Private Duty Nursing.

Miss Lucy Drew has resigned her position as night supervisor, Sherbrooke Hospital, and is succeeded by Miss Galleys.

JEFFERY HALE'S HOSPITAL, QUEBEC: Miss Nellie McKie has accepted a position on the staff of the Emanuel Hospital, Portland, Ore.

Miss McCallum has accepted a position with Price Brothers at River Bend, P.Q.

Miss McHarg has returned from her vacation, which she spent visiting the Canadian West and California.

Miss Hannah Ford has accepted a position with the Canada Pulp and Paper Company at Three Rivers, P.Q.

The sympathy of the members of the Alumnae is extended to the Misses Richardson in the death of their mother.

### SASKATCHEWAN

MOOSE JAW: The Schools of Nursing of the Providence and the Moose Jaw General Hospitals have arranged a combined lecture course for this year. Such a scheme has been under consideration for some time and at the September staff meeting a committee was appointed, which decided that four subjects would be tried, two to be given in the class-room at each hospital. So far the arrangement has proved satisfactory both to the doctors who lecture and to the schools. In all probability the plan shall include all subjects next year.

Miss Joan Moir (Providence Hospital), is in charge of the hospital at Southey, Sask.

Miss Stella Ryckman has gone to Seattle to take a course in X-Ray work.

CITY HOSPITAL, SASKATOON: At the last meeting of the Alumnae which was held at the Sanatorium, Dr. Banton gave an interesting talk on the care of tuberculosis. Tea was served later at the Nurses Home.

The first dance of the season was held at the Art Academy, on October 22nd. A large crowd attended and a very enjoyable evening was spent.

Mrs. J. Stevenson (Gertrude Wallace, 1925), of Calgary, Alberta, is visiting her parents here.

Miss Muriel Armitage (1928), of the Sanatorium staff, who has been ill for some time is convalescing at her home at Meota, Sask.

Miss Alice McGowan (1927), of Pilot Mound, Manitoba, has returned to the city and is doing special duty.

Miss Irene Baker (1927), has resigned from the staff of the City Hospital.

GREY NUNS' HOSPITAL, REGINA: A tea, also a sale of knitted wear and aprons was held by the Alumnae on September 25th. Mrs. McLean and Mrs. Trudelle presided at the tea table, and in spite of the unpleasant weather there was a good attendance.

On October 5th, a very successful sale of home cooking was held.

### VICTORIAN ORDER OF NURSES

#### APPOINTMENTS

Miss Rhoda Campbell (Department of Public Health Nursing, University of Toronto) is to open the new district of Kirkland Lake.

Miss Edith Raillton, in charge of district of Barrie, succeeding Miss Mildred Thomas, who resigned.

Miss Laura Spearing (Brantford General Hospital), to staff in Border Cities.

Miss Anna McFarland (School for Graduate Nurses, McGill University), in charge of Huntville district, replacing Miss Alice Hunt, transferred to Toronto.

Miss Bessie Wilson (Department of Public Health Nursing, University of Toronto), to staff, Pembroke district, replacing Miss Bessie Sweeney, who resigned to be married.

Miss Viola McFaul to the staff in St. Catharines.

Miss K. E. Beattie, in charge, district of Stratford, to replace Miss Marjorie Stevens, who has resigned to be married.

Miss B. W. McRoberts, of the Cornwall, staff has been granted leave of absence for three months.

Miss Jessie Durrell has been transferred to take charge of the district of Renfrew.

Miss Emma Elliott has returned to duty in Timmins after a leave of absence on account of illness.

### C.A.M.N.S.

The Overseas Nursing Sisters Association of Canada was organised on July 8th, 1929, in Montreal, with Mrs. S. Ramsey elected president, and Miss Margaret Macdonald appointed honorary president.

The Association shall meet biennially, coinciding in time and place with the general meeting of the Canadian Nurses Association. Nurses eligible for membership are those who are members of local associations and who have served overseas and also all nursing sisters who served overseas, who are on, or who have been honourably discharged from His Majesty's Service.

The objects for which the nursing sisters have formed a national association are:

(1) To foster the spirit of Patriotism and love for our King and Country, and to promote National Peace.

(2) To promote a greater feeling of unity and friendship between all Nurses who have served overseas.

(3) To act as a body when occasions arise which call for united effort.

Address of secretary-treasurer is: Mrs. W. Petch, 396 Olivier Avenue, Westmount, P.Q.

WINNIPEG: A general meeting of the Nursing Sisters' Club was held in the Nurses Home of the General Hospital on November 1st, when the president, Miss M. McGilvray occupied the chair, and also gave a very interesting talk on the events of the I.C.N. Congress, with special reference to the entertainment of, and courtesies extended to the Nursing Sisters.

The proposed Constitution and By-laws for an Overseas Nursing Sisters' Association of Canada were discussed, exception was taken to the fact that Nursing Sisters having served in Canada only were not eligible for membership. The Club voted in favour of an amendment to the effect that any nurse who has worn the King's uniform shall be accepted. The local association is honoured by having as members, Mrs. Howard, who served in the North-West Canada Expedition, and Mrs. J. H. R. Bond, who won the coveted medal of the Egyptian Campaign. Mrs. Bond also served in the South African War, and is the originator of the present military veil in Canada.

A resolution was passed in favour of Nursing Sisters only being employed on the nursing staffs of the Department of Pensions and National Health, and the Civil Service of Canada. The Canadian Legion also submitted this matter as being the wish of the returned men.

Several sisters volunteered to assist in the Poppy Day Campaign. Items of local interest were discussed, after which a delightful tea was served, kindly provided by Miss M. McGilvray and Miss K. Ross. A vote of thanks was passed to Miss J. Grant,

superintendent of nurses, for extending to the Club the use of the Nurses Home.

The nursing sisters and friends met for their eleventh Armistice Tea on November 9th in the Hudson's Bay dining room. Miss M. McGilvray, president of the Club, and Miss K. McLearn received the guests. Bouquets of roses and chrysanthemums centred the tea table at which Mrs. Gordon Cooper, Mrs. D. Moulden, Mrs. A. McLeod and Mrs. A. McKean presided.

The sympathy of the Club is extended to Miss Brighty, who has been confined for some months in the King Edward Memorial Hospital.

Miss M. M. Johnston has been in the General Hospital for a lengthy period, and is the able secretary of the Club this year too.

Miss A. Canning, who underwent an operation some time ago, is back on the nursing staff of the T. Eaton Company.

Mrs. R. V. Scott and Miss J. Roberts have been taken on the staff of the Deer Lodge Convalescent Hospital.

Miss E. F. Hudson, M.R.R.C., has severed her connection with the Manitoba Canteen Board, and is now with the Federal Department of Immigration.

## BIRTHS, MARRIAGES, AND DEATHS

### BIRTHS

**BADKE**—On October 4th, 1929, at Toronto, to Mr. and Mrs. George Badke (Esther Armbrust, St. Catharines General Hospital, 1922), a daughter (Eleanor Caroline).

**BOSWELL**—On September 29th, 1929, at Kitchener, to Mr. and Mrs. Edward C. Boswell, of Baden, Ont. (Phoebe Smith, Kingston General Hospital, 1928), a son (Walter Edward).

**CRAM**—On August 18th, 1929, at Ottawa, to Mr. and Mrs. Alex. Cram (Mabel Bonell, Lady Stanley Institute, Ottawa), a daughter.

**CRAWFORD**—On June 3rd, 1929, at Beirut, Syria, to Mr. and Mrs. Archie Crawford (Mary Pickard, Royal Victoria Hospital, Montreal, 1922), a son (John Pickard).

**FALLON**—On October 14th, 1929, at Kingston, to Mr. and Mrs. V. Fallon (Hotel Dieu, Kingston, 1919), a son (Francis Michael).

**FYFE**—Recently, at Regina, to Mr. and Mrs. Fyfe (Grey Nuns' Hospital, Regina, Sask.), a son.

**GARNER**—On August 13th, 1929, at Ottawa, to Mr. and Mrs. Chas. Gardner (Eleanor Ross, Ottawa Civic Hospital), a daughter.

**GIBBARD**—On September 16th, 1929, at Ottawa, to Mr. and Mrs. James Gibbard (Amy Gunn, Wellesley Hospital, Toronto, 1927), a son.

**HALL**—On September 3rd, 1929, at Toronto, to Mr. and Mrs. J. H. Hall (Marjorie M. Wilson, Grace Hospital, Toronto, 1917), a daughter (Vera Marion).

**HAMMOND**—On October 16th, 1929, at Toronto, to Mr. and Mrs. Jas. Hammond (Nora Gordon, 1926, Toronto General Hospital), a son.

**KENNEDY**—On October 16th, 1929, at Toronto, to Mr. and Mrs. T. A. Kennedy (Ruby Cameron, 1919, Toronto General Hospital), a daughter.

**LEAMING**—In June, 1929, to Mr. and Mrs. Charles Leaming (Pearl Beckett, Wellesley Hospital, Toronto, 1927), a son.

**LUMSDEN**—On October 8th, 1929, at Hamilton, to Mr. and Mrs. Hugh Lumsden (Ida May Latimer, Hamilton General Hospital, 1926), a daughter (Joyce Elizabeth).

**MAHOOD**—On October 22nd, 1929, at Ottawa, to Dr. and Mrs. A. E. Mahood (Hazel Johnston, Lady Stanley Institute, Ottawa), a son.

**MANN**—On August 19th, 1929, at Toronto, to Mr. and Mrs. Douglas Mann (E. Dorothy McWilliams, Grace Hospital, Toronto, 1917), a son (John).

**MANSFIELD**—On October 25th, 1929, at Ottawa, to Mr. and Mrs. Leland Mansfield (Catherine Paris, Toronto General Hospital), a son.

McCRIMMON—On October 1st, 1929, at Toronto, to Mr. and Mrs. Murray McCrimmon (Marion McLennan, 1922, Toronto General Hospital), a son.

MONTGOMERY—On October 17th, 1929, at Toronto, to Dr. and Mrs. R. C. Montgomery (Margaret Jackson, 1923, Toronto General Hospital), a son.

MOONEY—On October 23rd, 1929, at Gananoque, Ont., to Mr. and Mrs. F. Mooney (Mary E. Jewy, Hotel Dieu, Kingston, 1926), a daughter.

PENTECOST—On August 7th, 1929, at Toronto, to Dr. and Mrs. Reginald S. Pentecost (Jean Isobel Henry, Grace Hospital, Toronto, 1927), a daughter (Barbara Jean).

SMALL—On July 8th, 1929, at San Francisco, Cal., to Mr. and Mrs. Philip Small (Leonore Mitton, Royal Victoria Hospital, Montreal, 1920), a daughter (Elizabeth Anne).

WATERMAN—Recently, at Ottawa, to Mr. and Mrs. Waterman (Marjorie Clark, Jeffrey Hale's Hospital, Quebec), a daughter.

#### MARRIAGES

ARNOTT—BURLEY—On August 16th, 1929, at Belleville, Ont., Annie Laura Burley to Clarence Robert Arnott.

BRICELAND—McDONALD—Recently, at Wolfe Island, Ont., Myrtle Elizabeth McDonald (Hotel Dieu Hospital, Kingston, 1927), to W. L. Briceland, of Rochester, N.Y.

CARROLL—CARR—On September 14th, 1929, Anna Carr (Wellesley Hospital, Toronto, 1927), to William Carroll.

CARTER—TAIT—On July 13th, 1929, at Castleton, Ont., Jessie Marion Tait to Earl A. Carter, Cocobyville, Ont.

CONNERY—LOWRY—On September 14th, 1929, at Pakenham, Ont., Dorothy M. Lowry (Ottawa Civic Hospital, 1927), to James Connery, Pakenham, Ont.

CROCHER—BATE—On September 3rd, 1929, at Newcastle, N.B., Alice Muriel Bate (Royal Victoria Hospital, Montreal, 1921), to Hubert LeRoy Crocher.

DEACOFF—THURLOW—On August 21st, 1929, at Schreiber, Ont., Helen Christine Thurlow (Grace Hospital, Toronto, 1927), to James McDonald Deacoff, Toronto.

DeBELLE—STEVENS—On July 20th, 1929, at Amherst, N.S., Hazel May Stevens (Royal Victoria Hospital, Montreal, 1928), to John Ernest DeBelle, M.D.

DIXON—CURRAN—On October 16th, 1929, at Toronto, Henrietta Curran (St. Catharines General Hospital, 1921), to James Dixon, Port Dalhousie, Ont.

DUNNING—YOUNG—On October 19th, 1929, at Ottawa, Mornington (Morna) C. Young (Ottawa Civic Hospital, 1926), to Dr. Gregory W. Dunning, Ottawa.

EDWARDS—DUNFIELD—On September 10th, 1929, at Ottawa, Marjorie Belle

Dunfield (Lady Stanley Institute, 1924), to Reginald Edwards, Montreal.

ELLIOT—COMMERFORD—On October 2nd, 1929, at Montreal, Irene Commerford (Women's General Hospital, Montreal, 1925), to Jack Elliott. At home, Toronto, Ont.

ETHIER—TULLOCK—On August 29th, 1929, Eleanor Lilian Tullock, of Stirling, Ont., to Albert Edward Ethier, Belleville, Ont.

FINDLAND—DAVY—On September 6th, 1929, at Kingston, Audry Davy (Kingston General Hospital, 1928), to Hugh Findland.

GILLRIE—MAY—At Calgary, Alta., November 9th, 1929, Edna Beatrice May (Jeffrey Hale Hospital, Quebec, P.Q.), to William Walsindham Gillrie, of Calgary.

GRAHAM—CHASE—On September 17th, 1929, at Ottawa, Amy Chase (Ottawa Civic Hospital, 1927), to Cyril Graham, Ottawa.

HANNAN—LYONS—On September 3rd, 1929, at Kingston, Ruth Agnes Lyons (Kingston General Hospital, 1928), to Dr. Jason Albert Hannah.

McKENNA—WILSON—On October 5th, 1929, at Ottawa, Margaret L. Wilson (Ottawa Civic Hospital, 1926), to Arthur McKenna, Ottawa.

McLAUGHLIN—PALMER—On September 17th, 1929, at Ottawa, Marjorie Palmer (Ottawa Civic Hospital, 1927), to Wilfred McLaughlin, Toronto.

NATHANSON—TRUMAN—Recently, at New York, Kathleen Truman (Hamilton General Hospital, 1926), to Arnold Nathanson, New York.

OVEREND—HOBDEN—On October 7th, 1929, at Toronto, Reita R. Hobden (Hamilton General Hospital, 1921), to Harold J. Overend, Ph.D., Orillia, Ont.

PITT—THORPE—On September 4th, 1929, at Toronto, Florence Mae Thorpe (Grace Hospital, Toronto, 1926), to John Alfred Pitt, Dryden, Ont.

ROCKWELL—LYNDS—On July 16th, 1929, at Saint John, N.B., Margaret Estelle Lyns (Royal Victoria Hospital, Montreal, 1925), to William H. Rockwell.

SABITINI—WOODFORD—On February 7th, 1929, at New York, Eunice M. Woodford (Connaught Training School for Nurses, Toronto, 1919), to Dr. R. F. Sabitini, New York.

SLOAN—MERWIN—On September 11th, 1929, at Peterborough, Ont., Jean Merwin (Wellesley Hospital, Toronto, 1920), to Max Sloan.

TOVELL—BALLANTYNE—On July 6th, 1929, at Chicago, Ill., Lavina Ballantyne (Kingston General Hospital, 1926), to Dr. Ralph M. Tovell, Rochester, Minn.

WAGSTAFF—LEACH—On October 16th, 1929, at St. Catharines, Susan Leach (St. Catharines General Hospital, 1925), to James Wagstaff.

**WARD—LOVELAND** — In August, at Montreal, Ruth Loveland (Jeffery Hale's Hospital, Quebec, 1927), to Arthur Ward, Bury, P.Q.

**WATTERSON—PEARSON** — On September 17th, 1929, at Ottawa, Martha I. Pearson (Ottawa Civic Hospital, 1926), to M. E. Watterson, Kemptville, Ont.

**WILL—RONSON** — On October 19th, 1929, at Brantford, Ont., Thelma I. Ronson (Hamilton General Hospital, 1928), to Frank Will, Hamilton.

**WILSON—PATERSON** — On November 6th, 1929, at Ladner, B.C., Gertrude Paterson (Vancouver General Hospital, 1924), to Ross Wilson.

**WHITLA—GRAHAM** — On July 13th, 1929, at Edmonton, Alta., Olive Wisdom Graham (Royal Victoria Hospital, Montreal, 1923), to William H. Whitla.

**WISEMAN—HIGGINSON** — On September 28th, 1929, at Inkerman, Ont., Lillian Higginson (Kingston General Hospital, 1928), to Reginald Wiseman, Napanee, Ont.

#### DEATHS

**HALPIN** — On November 5th, 1929, suddenly, at her home in Wallaceburg, Ruth Halpin (Hamilton General Hospital, 1920).

**MURPHY** — On September 28th, 1929, in New York City, Vivian Murphy (Hotel Dieu Hospital, Kingston, 1918).

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# THE CANADIAN NURSE

## INDEX

745

Volume XXV.

Year 1929

January.....	Pages 1- 56	May.....	Pages 225-228	September.....	Pages 449-594
February.....	" 57-112	June.....	" 281-336	October.....	" 595-650
March.....	" 113-168	July.....	" 337-392	November.....	" 651-706
April.....	" 169-224	August.....	" 393-448	December.....	" 707-762

### BIOGRAPHICAL NOTES, ETC.:

Andersen, Petrea K.....	236	de Joannis, Jeanne.....	295
Andrews, Mrs. Lancelet.....	236	Johns, Ethel (with photograph).....	674
Arntzen, Andrea.....	296	Larsson, Sister Berghjot.....	295
Becker, Kirsten.....	236	Llerena, Hortensiz Perez.....	235
Bennie, Mrs. W. G.....	238	Kehrer, Meta.....	236
Breay, Margaret.....	236	Mitchell, Alexandra McD.....	238
Browne, Jean E.....	416	Musson, Ellen Mary (with photograph).....	119
Brownson, Ellen.....	368	McKenny, Cecilia.....	237
Chan, Agnes.....	235	Noyes, Clara D. (with photograph).....	118
Chaptal, Mlle.....	294	d'Ornellas, Mere Catherine.....	295
Clayton, S. Lillian.....	238	Pearse, Helen Lucy.....	236
Cox-Davies, Rachel.....	236	Petersen, Cornelia.....	235
Eldredge, Adda.....	239	Platou, Harriett.....	296
Feldthaus, Clara.....	235	Reimann, Christiane (with photograph).....	120
Fenwick, Mrs. Bedford (with photograph).....	117	Romanowska, J.....	237
Francis, Susan C.....	239	Russell, E. Kathleen (with photograph).....	417
Gage, Nina D. (with photograph).....	117	Serton, M.....	237
Goodrich, Annie A.....	234	Shi, Hsi En.....	234
Gordon, Ann S.....	238	Slater, Catherine Frances.....	237
Grenier, M.....	295	Sorensen, Petrea.....	235
Guevara, Martina.....	235	Strong, Mrs. Rebecca (with photograph).....	296, 478
Gunn, Jean I. (with photograph).....	119	Suffczynska, Miss.....	237
Guttormsen, Gunhild Marie.....	296	Terpatra, A.....	237
Hartley, Annie J. (with photograph).....	132, 401	Tscherning, Mrs. Henny.....	234
Healy, Nellie.....	237	Villiers, Susan A.....	368
Hellemans, Jeanne.....	294	Wesseling, S. A.....	237
Hervy, Antoinette.....	295	Wu, Lillian.....	243
Horn, Frances.....	238		
Horn, Maren.....	296		
Hsun, Mr. Kuo Jung.....	235		
Ingram, Ruth.....	235		

BOOK REVIEWS ..... 21, 89, 145, 196, 250, 307, 376, 417, 630, 682, 734

### DEPARTMENT OF NURSING EDUCATION:

Community Need in Relation to the Education of the Nurse.....	Marie Chaptal	544
Concerning Co-operation.....	S. Persis Darrach	676
Educational Development in the School of Nursing.....	Sister Jovita	721
Eliminating the Unfit from the School of Nursing.....	Elizabeth W. Odell	723
Exchange Scholarships.....	Alice Lloyd Still	509
Florence Nightingale's Birthday Was Kept in China, How.....	Gladys Stephenson	415
Gift to Nursing Education.....		675
Graduation.....	Dr. Gordon Jackson	356
History of Nursing Society, McGill University.....	Ursula Whitehead	246
McGill University School for Graduate Nurses.....		301
Mental Hygiene and Nursing.....	Dr. G. A. Davidson	243
Methods in Teaching Ethics.....	Charlotte Talley	352
Nursing Education in a University.....	Gertrude E. Hodgman	22
Organisation of Post-Graduate Study in Nursing.....	Rachel Cox-Davies	550
Preparation of a Curriculum, The.....	Dr. Stanley Ryerson	535
Staff Education.....	Eileen C. Flanagan and Kathleen B. Hill	241
State Supervision in Schools of Nursing.....	Adda Eldredge	545
Status of Nursing Among French Canadians.....		133
Summer Relief Nurses.....	Pearl L. Morrison	245
Teaching of Bacteriology, The.....	Ruth F. Walden	413
Training of a Public Health Nurse, The.....	E. Kathleen Russell	78
Training School Records in Smaller Hospitals.....	C. E. Guilloid	298
Training School Problems.....	C. E. Guilloid	187
Trends and Developments in Vocational Education.....	Dr. W. W. Charters	541
University Schools of Nursing.....	Annie W. Goodrich	512
Vocational Guidance.....	Grace M. Fairley	137

## DEPARTMENT OF PRIVATE DUTY NURSING:

Ante-Operative and Post-Operative Care	191
Constipation: Its Cause and Correction	Dr. N. A. Page 618
Constipation: Its Cause and Correction—Correspondence	725
Economics of Nursing, The	Elizabeth Fox 576
Eczema	Dr. Harold Orr 303
Emotional Development of the Pre-School Child, The	S. Leslie Bell 25
Hourly Nursing	Margaret L. Moag 138
Immunology and Prophylaxis	Dr. W. T. Shirreff 418
Interpretation of Some Clinical Laboratory Studies	Dr. A. G. McGhie 357
Interesting Case of Diphtheria, An	Dr. F. S. MacPherson 248
Modern Developments in Private Nursing	Isabel Macdonald 574
Most Interesting Case, My	Maureen Carley 249
Nursing Care of Eczema (illustrated)	Ethel English 305
Nursing of the Mentally Sick, The	Claudia M. Fleming 83
Status and Problems of the Private Duty Nurse	A. S. Gordon, Agnes Chan, Jessie Bicknell, E. C. Kalteft and Janet Geister 572

## DEPARTMENT OF PUBLIC HEALTH NURSING:

Co-Relating Health Education in a City Secondary School	K. E. Dowler 624
County Health Unit—England	Ruby M. Hamilton 678
Day with the Sisters of Charity in Zagreb, A	Mary Millman 194
Developments in the Public Health Field	Dr. G. B. Roatta 556
Fighting Diphtheria in New Brunswick	Huilota Dykeman 143
Health Exhibition in Australia, A	Elinor N. Wade 144
Home Nursing Training	Anne Anderson Perry 366
Imperial Baby Week	255
Industrial Nursing	K. S. Perrin 86
Mental Health: In the Home	Isobel MacIntosh 364
In the Hospital	Gertrude P. Garvin 362
In Industry	Muriel Mackay 361
In the Nursery School	Joyce Davidson 425
In the School	Emma de V. Clarke 422
Mental Hygiene and Public Health	Dr. S. R. Laycock 728
New Town Treatment Clinic	M. E. Misner 30
Public Health Nurses' Bulletin	427
Public Health Nursing Programme	Nan McMann 5
Red Cross Nursing Programme, The	Mrs. Maynard Carter and Lucie Odier 562
Regional Conference—Victorian Order of Nurses	195
School Teacher's Health, The	626
Stowe House: An Open-Air School	M. E. Misner 32
System of School Medical Inspection	Dr. F. S. Burke 251, 307
Training Public Health Nurses	Dr. H. W. Hill 29
True Story, A	Contributed 628
EDITORIALS	401, 604, 660

## ILLUSTRATIONS:

Board of Directors, I.C.N.	453
Breay, Margaret (photograph)	490
Chaptal, Mlle. (photograph)	464
Chateau Laurier, Ottawa	12
Clock Tower in Ordnance Yard, Halifax	184
Committee on Arrangements, Montreal	467
Exhibits	479-485
Farmer Smith's Camp for Crippled Children, Little Guests at	186
Federal Parliament Buildings at Night	9
Fenwick, Mrs. Bedford (photograph)	117
Gage, Nina D. (photograph)	117
Garden Party, McGill University Campus	459
General Session, International Congress of Nurses	455
Gunn, Jean I. (photograph)	119
Hartley, Annie J. (photograph)	132, 401
Hopital Notre Dame, Montreal	291
Hotel Dieu, Montreal	289
Japanese Luncheon	461
Johns, Ethel (photograph)	674
Letter Thanking Colony of Prince Edward Island for Red Cross Supplies to Crimea (facsimile)	240
Library, Winnipeg General Hospital	672
Members of Five New Countries Admitted to International Council of Nurses, 1929	457
Memorial Chamber, Victory Tower, Ottawa	468
Montreal Art Gallery	193
Montreal General Hospital	287

Musson, Ellen Mary (photograph).....	119
Noyes, Clara D. (photograph).....	118
Old Fort at Annapolis Royal.....	185
Pauline, with deformed foot.....	172
Pauline, with foot straightened.....	172
Province House of Nova Scotia.....	183
Reimann, Christiane (photograph).....	120
Roddick Memorial Gate, The.....	82
Roof Playground, War Memorial Hospital, London (illustration).....	174
Royal Victoria Hospital, Montreal (photograph).....	290
Russell, E. Kathleen (photograph).....	417
Strong, Rebecca (photograph).....	478
War Memorial Children's Hospital, London (illustration).....	173
<b>MISCELLANEOUS:</b>	
After the Congress, the Maritimes (illustrated).....	183
Ante-Operative and Post-Operative Care.....	191
Breast Feeding in Health Centres (illustrated).....	663
Call of Eternal Youth, The.....	Mabel E. Finch 613
Canadian Council on Child Welfare—Annual Meeting, 1928.....	15
Canadian Tuberculosis Association, Scholarship Tour.....	17
Cancer Mortality, Reduction in.....	616
Care of Post-Poliomyelitis Patients.....	Gladys E. Smiley 671
Care of the Premature Infant (illustrated).....	Edgeworth Murray 605
Challenge of the Future, The.....	Florence H. M. Emory 227
Child Development.....	Bird T. Baldwin 607
Child Welfare in New Zealand.....	Olive M. Garrood 62
Citizen in Relation to the Public Health Programme, The.....	Helen R. Y. Reid 597
Clinical Laboratory Studies, The Interpretation of.....	Dr. A. G. McGhie 357
Community Need in Relation to the Education of the Nurse, The.....	Marie Chaptal 544
Concerning Co-operation.....	S. Persis Darrach 676
Congenital Atelectasis.....	296
Congress, 1929, The I.C.N. (illustrated).....	451
Constipation: Its Cause and Correction.....	Dr. N. A. Page 618
Co-Relating Health Education in a City Secondary School.....	K. E. Dowler 624
Cost of Sickness, The.....	Dr. J. L. Biggar 339
Cost of Hospital Service.....	Dr. G. Harvey Agnew 181
County Health Units—United States of America.....	Laura M. Gamble 718
Curriculum, The Preparation of a.....	Dr. Stanley Ryerson 535
Day with the Sisters of Charity in Zagreb, A.....	Mary Millman 194
Developments in the Public Health Field.....	Dr. G. B. Roatta 556
Diet in Disease.....	E. Laura Cody 411
Economics of Nursing, The.....	Elizabeth Fox 576
Eczema.....	Dr. Harold Orr 303
Eczema, Nursing Care of (illustrated).....	Ethel English 305
Education of the Crippled Child (illustrated).....	Ethel Tensdall 171
Education of the Nurse, Community Need in Relation to.....	Marie Chaptal 544
Education and Service of the Nurse.....	612
Electric Shock, Treatment of.....	P. Lumly 232
Emotional Development of the Pre-School Child, The.....	S. Leslie Bell 25
Exchange Scholarships.....	Alice Lloyd Still 509
Exhibits, I.C.N. Congress, 1929 (illustrated).....	478
Florence Nightingale's Birthday Was Kept in China, How.....	Gladys Stephenson 415
Future, The.....	Adelaide Nutting 492
Future of Mental Nursing, The.....	399
Greeting to the Canadian Nurse, A.....	Nina D. Gage 3
Health Centres, Breast Feeding in (illustrated).....	Dr. A. B. Chandler 663
Health Education in City Secondary Schools, Co-Relating.....	K. E. Dowler 624
Health Examinations, Value of Periodic.....	Dr. A. Grant Fleming 283
Health Preservation through Adequate Diet.....	Sister Irene Marie 176
Hospitals of the Montreal Hospital Council (illustrated).....	286
Hospital Service, Cost of.....	Dr. G. Harvey Agnew 181
Housewives' Neurosis.....	Mary Chadwick 230
Immigration, Medical Aspects of.....	Dr. J. D. Page 395
Immunology and Prophylaxis.....	Dr. W. T. Shirreff 418
Importance of the Social Life of the Student Nurse, The.....	Beatrice Creasy 128
International Council of Nurses' Congress.....	115, 197, 256, 313, 368
International Council of Nurses: Aims.....	Nina D. Gage 4
Biographies, Grand Council.....	294
Founders and Officers.....	116
Grand Council.....	234
International Council of Nurses.....	74

Interpretation of Some Clinical Laboratory Studies, The.....	Dr. A. G. McGhie	357
Jean Browne, Miss, in Geneva.....		416
Lazaretto at Tracadie, N.B., The.....	A Sister of St. Martha	348
League's Latest Enterprise, The.....	Jean E. Browne	10
Legislation in Nursing.....	E. M. Musson	552
Maritimes, The: After the Congress (illustrated).....		183
Maternal Mortality with Questionnaire, National Council of Women.....		125
Medical Aseptic Technique.....	Ella M. Forrest	715
Medical Aspects of Immigration.....	Dr. J. D. Page	395
Mental Hygiene Movement in Canada, The.....	Dr. Chas. F. Martin	59
Mental Hygiene and Nursing.....	Dr. G. A. Davidson	243
Mental Nursing, The Future of.....		399
Mentally Sick, The Nursing of the.....	Claudia M. Fleming	83
Modern Developments in Private Nursing.....	Isabel Macdonald	574
National Council of Women—Maternal Mortality, with Questionnaire.....		125
Need for Publicity in Nursing, The.....	Gertrude Cowlin	522
Nervous Troubles of Children.....		407
New Brunswick Association of Registered Nurses.....	Gertrude Williams Jones and Emma J. Mitchell	18
Nurses' Bulletin, British Columbia.....		427
Nurse as a Citizen, The.....	Bertha Wellin	505
Nurse and the Law, The.....	Harold Fisher	70
Nurses' Library, Winnipeg General Hospital (illustrated).....	Rachel N. Fogarty	672
Nursing of the Mentally Sick, The.....	Claudia M. Fleming	82
Occupational Therapy.....	Genevieve L. Hurd	13
Organisation of Post-Graduate Study in Nursing, The.....	Rachel Cox-Davies	550
Ottawa (illustrated).....		8
Poliomyelitis.....		408
Poliomyelitis Epidemic, Report on, in Manitoba, 1928.....		297
Post-Poliomyelitis Patients, Care of.....	Gladys E. Smiley	671
Post-Graduate Study, The Organisation of.....	Rachel Cox-Davies	550
Preparation of a Curriculum, The.....	Dr. Stanley Ryerson	535
Premature Infant, Care of (illustrated).....	Edgeworth Murray	605
Pre-School Child, The.....	Dr. G. A. Lamont	799
President's Address.....	Nina D. Gage	486
Professional Obligations, Our.....	Jean E. Browne	121
Progress and Opportunities in the Field of Nursing.....	A Student Nurse	130
Public Health Field, Developments in.....	Dr. G. B. Roatta	556
Public Health Nursing Programme.....	Nan McMan	5
Publicity in Nursing, The Need of.....	Gertrude Cowlin	522
Red Cross Nursing Programme, The.....	Mrs. Maynard Carter and Lucie Odier	562
Reduction in Cancer Mortality.....		616
Report on the Poliomyelitis Epidemic in Manitoba, 1928.....		297
Royal New Zealand Society for the Health of Women and Children.....	Aileen Partridge	64
Rural Nursing.....	Alexandra Wacker and Nikica Bovolini	527
Rural Nursing as Health Centres.....	Mary K. Nelson	530
Rural Nursing from the Viewpoint of the Public Health Nurse.....	Elizabeth Smellie	531
Scientific Method in Social and Health Work, The.....	Julius Tandler	498
Smallpox.....		351
Social Life of the Student Nurse, The Importance of.....	Beatrice Creasy	128
Social and Health Work, Scientific Methods in.....	Julius Tandler	498
State Supervision in Schools of Nursing.....	Adda Eldredge	545
Status and Problems of the Private Duty Nurse, The.....	A. S. Gordon, Agnes Chan, Jessie Bicknell, E. C. Kaltoft and Janet Geister	572
Survey of Nursing Education in Canada.....	Dr. George M. Weir	653
Treatment for Electric Shock.....	P. Lumly	232
Trends and Developments in Vocational Education.....	Dr. W. W. Charters	541
University Schools of Nursing.....	Annie W. Gooderich	512
Value of Periodic Health Examinations, The.....	Dr. A. Grant Fleming	283
Venereal Disease Clinic, The.....	Dr. Gordon Bates	402
Victorian Order Supervisors Demonstrate to McGill Students.....	M. L. Moag	433
Vocational Education, Trends and Developments in.....	Dr. W. W. Charters	541
Watchword, The—"Service".....	Ethel G. Fenwick	490
NEWS NOTES.....	36, 92, 147, 202, 259, 315, 369, 428, 631, 684,	736
OBITUARY: Maxwell, Anna C.....		123
OFFICIAL DIRECTORY.....	45, 101, 155, 211, 267, 323, 379, 435, 581, 637, 691,	749
REPORTS		
New Brunswick Association of Registered Nurses, Historical.....		18
Poliomyelitis Epidemic in Manitoba, 1928.....		297
Provincial Meetings, Annual Reports, British Columbia, Ontario and Saskatchewan.....		257



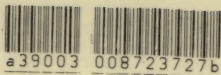


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